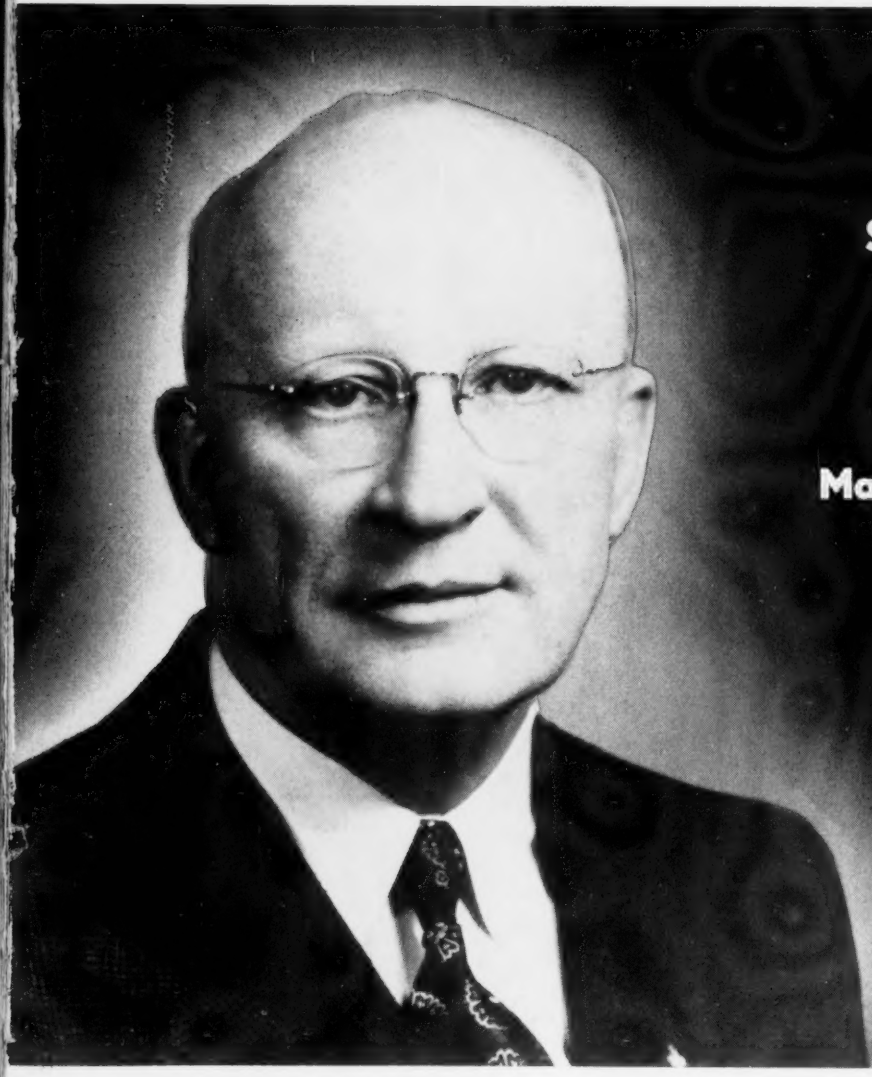
HOSPITAL Topics

THE NEWS MAGAZINE FOR HOSPITALS



CLARENCE E. COPELAND

Small Hospital Has Heavy Emergency Load

page 10

Make Your Accounting System a Management Tool

page 18

Small Hospitals Without Pharmacists

page 28

BUYER'S GUIDE
Page 48

FEBRUARY | 1955

"Substantial Progress"*

IN EXCRETORY UROGRAPHY

NEW

- RADIOPACITY..*High*
- EXCRETION..*Rapid*
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- VEIN CRAMP..*Rare*
  (in approximately 1% of cases)

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Hypaque® SODIUM

SUPPLIED: 50% sterile aqueous solution, ampuls of 30 cc., boxes of 1, 10 and 25 (with 1 cc. test ampuls).

*Moore, T. D.; and Mayer, R. F.: Hypaque: An Improved Medium for Excretory Urography. A Preliminary Report of 210 Cases. Paper read at 48th Annual Meeting of Southern Medical Assn., St. Louis, Mo., Nov. 10, 1954.

Hypaque, trademark reg. U.S. Pat. Off., brand of diatrizoate sodium.

"In addition to the excellent quality of excretory urograms obtained with Hypaque the virtual absence of major side effects and the small percentage of minor side effects were notable."*

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...More and More Hospitals *Adopt* Aloe Contour Breast Pads

Late last fall, the Aloe Company introduced an entirely new shaped, absorbent breast pad. Now hundreds of hospitals in all parts of the country have adopted as routine this better way of handling the problem of excess lactation.

The experience of Creighton Memorial St. Joseph's Hospital, Omaha, Nebraska, is an example of the acceptance of this remarkably successful product. Mr. Francis Bath, Business Manager, writes:

"... We believe that St. Joseph's was one of the earliest of the hospitals to use this breast pad in the maternity department, where it has won favor not only with the personnel, but even more among the patients. We have had several mothers who have taken home as many as six boxes ...!

"Sister Mary Corneliana, O.S.F., O.B. Supervisor, is enthusiastic about the pad, as she finds it much more satisfactory than the sponges which were used formerly."

This shaped pad was one of those ideas the need for which had been felt for a hundred years or more, but about which little was done. Nurses and supervisors have always known that there must be a better way of stemming the flow of excess lactation in new mothers than that of using irritating gauze sponges, make-shift cut pads or lumps of cotton under the bra.

It takes hours of hospital personnel time to "manufacture" such improvised pads, and additional labor time to apply, with the results seldom satisfactory. Hospitals speedily recognized the obvious advantages of a prepared, scientifically designed pad, when we introduced it.

Aloe Takes No Credit for suggesting the shaped Breast Pad. Actually a physician friend of the Company decided that the time for such a pad was long overdue. Nature and common sense dictated the design. We merely placed the problem of production before an experienced manufacturer, with the stipulation that materials must be of the finest and that control of quality must be rigid.

The Natural Contour Shape and perfect absorbency of Aloe Contour Breast Pads are responsible for their instant acceptance. Anatomically formed to fit the breast with full coverage of nipple, areola and a generous adjacent area (3¾ inches in diameter), they are unobtrusive in appearance and afford complete protection to the patients' clothing. Patients, of course, overwhelmingly endorse them.

The Pads are made of cotton, filled with soft, highly absorbent cellulose —non-allergenic, non-irritating, helpful in preventing retracted and cracked nipples; a great aid in applying medication. They are packaged one dozen (average daily supply per mother) in an attractive carton; easy to dispense; labor saving; generally applied by the mother herself. Easy to store. They are disposable and therefore eliminate repeat sterilization. Patients usually want to purchase an extra supply from the hospital dispensary for continued use at home.

Among Aloe Contour Breast Pad users are:

Ball Memorial Hospital
Muncie, Indiana

Centro Asturiano Hospital
Tampa, Florida

Creighton Memorial St. Joseph's Hospital
Omaha, Nebraska

Good Samaritan Hospital
Sandusky, Ohio

Hutchins Memorial Hospital
Buford, Georgia

Lee Memorial Hospital
Fort Myers, Florida

Marymount Hospital, Garfield Heights, Ohio

McLaren General Hospital
Flint, Michigan

Mease Hospital, Dunedin, Florida

Mercy Hospital, Toledo, Ohio

Misericordia Hospital
Milwaukee, Wisconsin

Munroe Memorial Hospital
Ocala, Florida

Ohio Valley General Hospital
Wheeling, West Virginia

Passavant Memorial Hospital
Jacksonville, Illinois

Roper Hospital
Charleston, South Carolina

Self Memorial Hospital
Greenwood, South Carolina

South Carolina Baptist Hospital
Columbia, South Carolina

St. Anthony's Hospital
St. Louis, Missouri

St. Joseph's Hospital, Milwaukee, Wisconsin

St. Joseph's Mercy Hospital
Pontiac, Michigan

St. Luke's Hospital
Kansas City, Missouri

St. Mary's Hospital, Athens, Georgia

St. Mary's Hospital
Kansas City, Missouri

Tallahassee Memorial Hospital
Tallahassee, Florida

Tampa Municipal Hospital
Tampa, Florida

The Valley Hospital, West Point, Georgia

University of Kansas Medical Center
Kansas City, Kansas

Winter Haven Hospital
Winter Haven, Florida

If you have not seen the Pad, just jot your name on your hospital letterhead today. Sample and literature will be sent immediately.

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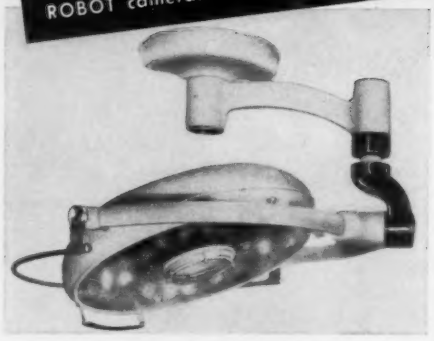
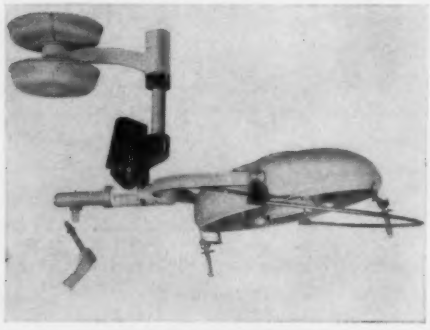


No. 61 – Dual offset arm without vertical adjustment.



No. 63 – With vertical adjustment and remote control (features which may be added to other model)

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LIGHT WHERE THE SURGEON NEEDS TO SEE — A fixture so easily moved that the surgeon's visual need is instantly met. Without breaking sterile technic, any member of the surgical team can direct the beam with only ounces of pressure on sterilized control handles.

MULTI-USE CENTER SPOTLIGHT — In addition to 4 major reflectors, an exclusive Center Pilot Spotlight provides extra penetrating power and an emergency lighting source. Projecting an 8-inch pattern deep into the incision, the pilot spot also acts as a pre-operative positioning guide to insure visual accuracy of light placement. An excellent auxiliary brain light or independent illuminator for ophthalmic surgery. Can be connected to automatic emergency circuit.

OBJECTIONABLE COUNTER-BALANCING BALL ELIMINATED — A newly devised INTERNAL CAM BALANCE obsoletes the conventional ball-type counterweight and provides "feather-touch" mechanical controls that are self-locking in any position.

ELIMINATES REPOSITIONING OF TABLE — A small central mounting with a dual offset arm provides continuing 360° rotations on 3 axes, without stops. Lamphead may be extended, lowered or tilted to any point within an 8'3" diameter circle, making it unnecessary to move operating table during any operation.

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HOSPITAL Topics

The News Magazine for the Hospital Staff

FEBRUARY, 1955, VOL. 33, NO. 2

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PERSONALITY OF THE MONTH

Clarence E. Copeland, administrator of the Missouri Baptist Hospital, St. Louis, has two consuming interests—hospitals and church work. In these two fields he has long been an active force in the state of Missouri.

Currently president of the American Protestant Hospital Association, his previous lay religious offices have included the presidency of the Missouri State Baptist Brotherhood, and moderator of the St. Louis Baptist Association—an organization consisting of 55 churches and 38,834 members.

In the field of health and hospitals also, Mr. Copeland has given unstintingly of his time and talents. Among his previous offices are president, Southwide Baptist Hospital Association; president, Missouri Hospital Association; and vice-president, St. Louis Hospital Council. He is now president of the last named organization.

He is a fellow, American College of Hospital Administrators, and member of the American and Mid-West Hospital Associations.

Although Mr. Copeland was born in Richmond, Va., and educated in Ohio, he has spent most of his adult years in St. Louis where he was engaged in business before joining the staff of the Missouri Baptist Hospital, in 1936, as financial secretary. He has been the hospital's administrator since 1943.

Mr. Copeland is married and has three children.

prescription pad

Fractional Gastric Analysis With Few Side Effects

Fractional gastric analysis may now be done with almost no disturbing side-effects to the patient.

Eli Lilly and Company offers Ampoules Histalog (histamine analog), which stimulate gastric secretion as powerfully as histamine but with only 1/25th the incidence of side-effects.

Because of this marked advantage, Histalog is recommended to replace histamine acid phosphate in the testing of gastric secretory capabilities. This test is used (1) to determine whether achlorhydria is present (to aid in the diagnosis of pernicious anemia) and (2) to measure the secretory capacity of the gastric glands (to aid in the diagnosis of carcinoma of the stomach or peptic ulcer).

Physicians who are using histamine acid phosphate are familiar with its systemic effects—generalized vasodilatation, fall in blood pressure, bronchoconstriction, stimulation of gastric secretion and gastro-intestinal motility, and allergic reactions.

Histalog's effect on the gastric secretion is quantitatively the same as that of histamine. In ordinary doses in humans, no significant change in blood pressure and only a minimal increase in pulse rate have been observed.

The most commonly observed side-effect associated with use of Histalog is flushing of the face, accompanied by a sense of warmth. But this occurs in approximately one-fifth of the patients, as contrasted to an incidence of three-fourths in those receiving histamine.

Headaches occur in approximately half the patients receiving histamine, but in only one to three percent of those given Histalog. Urticaria, faintness, and syncope rarely follow the use of this agent.

Ampoules Histalog are administered intramuscularly or subcutaneously. Each ampoule contains 50 mg. Histalog, or the dose which may be given adult patients of average weight. The minimal effective dose may be calculated on the basis of 0.5 mg. per kilogram of body weight.

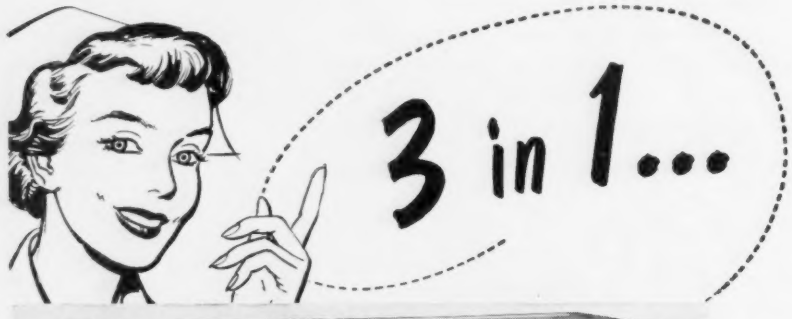
New Adrenocortical Ointment

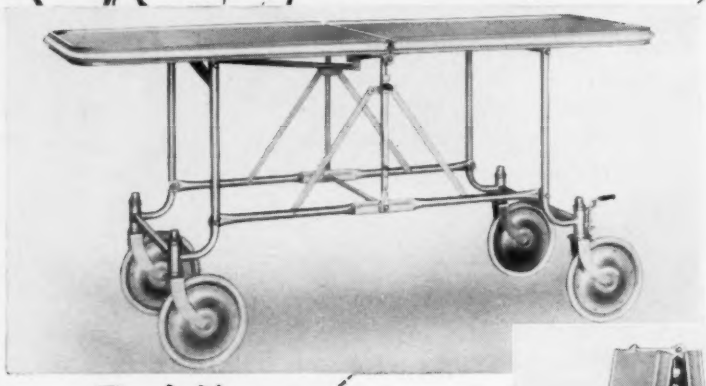
An important new development in adrenocortical therapy, Alflorone Acetate (Fludrocortisone acetate), can be expected to extend topical steroid therapy to many more patients, announced Sharp & Dohme, Division of Merck & Co., Inc., in releasing the new product.

A derivative of hydrocortisone (Compound F), Alflorone Acetate possesses an anti-inflammatory activity up to ten times as great on a weight-for-weight basis. The chemical designation of the new compound is 9, alpha-Flurohydrocortisone acetate.

The greater anti-inflammatory activity will significantly lower the quantity of the drug needed to produce a therapeutic effect comparable to that of hydrocortisone. Consequently, the lowered cost will make long-term treatment of chronic skin conditions more practical and economical, particularly in the treatment of widespread lesions.

Clinical reports show that the Alflorone topical ointment shares the same wide margin of safety and freedom from systemic effects and sensitization as do hydrocortisone topical ointments. Present indications are that any skin condition responding to an ointment of hydrocortisone will respond to the new product in one-tenth of the concentration.



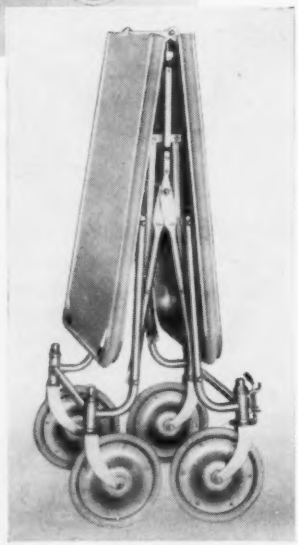


Folding Wheel Stretcher

Store three stretchers where you now store only one!

Folds and unfolds with ease—solves your temporary storage problems—it is the *only* folding wheel stretcher on the market today. The Gendron Model 870 is a full size stretcher, 26″ wide—72″ long when unfolded for use—but folds into a space saving 21″. Equipment consists of a litter of all steel construction, frame of sturdy welded tubing, with litter bumper, 10″ ball bearing wheels and rubber tires, swivel fork lock and ball bearing swivel journals, and aluminum bronze, conductive finish.

The Gendron 870 saves you space—*is low cost.* See it at your dealer or write direct to Gendron, Dept. H-55,—for further information.



GENDRON MODEL 870

Gendron Wheel Company

PERRYSBURG, OHIO

clinical notes

New Antihistaminic Clistin Maleate

Commonly used antihistaminic agents have been found to produce sedation in 10 to 60 percent of patients receiving these drugs.

Because of apparent advantages over most other antihistamines now in use, a new antihistaminic was studied from a practical clinical viewpoint—and it appears to answer the need where effective control of allergic symptoms with little risk of sedation is important.

Reporting in *American Practitioner*, Nov., 1954, Johnson administered Clistin Maleate (Carbinoxamine Maleate) to 116 patients in doses of 2 mg. or 4 mg. every three to 12 hours. Of the total 116 patients, 87 percent reported some relief of symptoms; in 76 percent the relief was graded as moderate to complete. In the group of 77 patients with acute rhinitis, 81 percent reported moderate to complete relief of their symptoms.

Undesirable side-effects were infrequent and usually mild in nature. Two individuals complained of dryness of mouth; one of dizziness; one of headache; one tingling of the scalp.

On the basis of effectiveness in controlling symptoms of allergic diseases, the drug appears to compare favorably with the most potent antihistaminic drugs, yet has a relatively low sedative liability when taken in dosage sufficient to control symptoms. It seems to possess the advantages of potent antihistaminic action and weak sedative properties.

Although the value of antihistaminic drugs in prophylaxis or abortion of the common cold is controversial, these drugs often give symptomatic relief from profuse nasal secretions, especially when given at the onset of symptoms. This was the case when the drug was given to patients with acute rhinitis which appeared to be non-allergic.

Reducing Neonatal Deaths

Alevaire, administered as a "fog" to newborn infants with excess mucous in the lungs, is showing spectacular results in reducing the high rate of infant mortality stemming from this cause.

Approximately 16,500 infants in the United States die each year from respiratory infections but might recover if obstructions in the air passages were removed, according to Ravenel. His report appears in *GP*, October 1954.

Once the breathing difficulty is solved, the underlying respiratory infection can then be treated with antibiotics and other measures to prevent dehydration and heart failure.

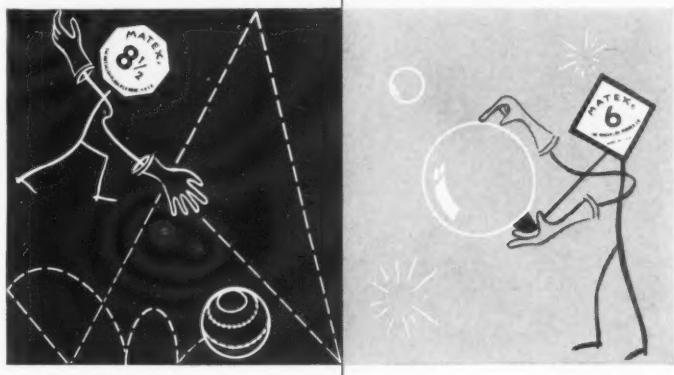
Before instituting this therapy, the author regarded these babies with a feeling of resignation and despair, realizing that an occasional recovery was due to natural stamina and not to therapy. In contrast, these young patients are now faced with enthusiasm and confidence.

Administered through a nebulizer in incubators or oxygen tents, the drug penetrates deep into the air passages.

Dramatic results were obtained in allergic bronchitis, bronchopneumonia, laryngotracheobronchitis, pertussis, bronchiectasis and other pulmonary diseases. It was also found that polio patients are able to ward off lung obstruction, lung collapse and pneumonia if they receive Alevaire, antibiotic drugs and oxygen.

YOU BENEFIT

from this compromise



LET'S FACE FACTS

The Massillon Rubber Company *could* make surgeons' gloves with higher tensile strength that would last even longer than they do. Or they *could* make gloves even thinner . . . that wouldn't last as long.

A balanced compromise between these two extremes is the practical answer.

In MATEX (white) and MASSILLON Latex (brown) you get the delicate balance of long glove life and comfortable, bare-fingered tactility that supplies the most in satisfaction, long service and economy.

And the KWIKSORT permanent size markings cut your labor costs. An untrained assistant can sort and pair KWIKSORT sizes by shape—even when gloves are inside out!

May we send the free folder, "Suggestions to make your gloves last longer"? You'll get extra use from gloves that are cared for properly.

MATEX Kwiksort MASSILLON LATEX

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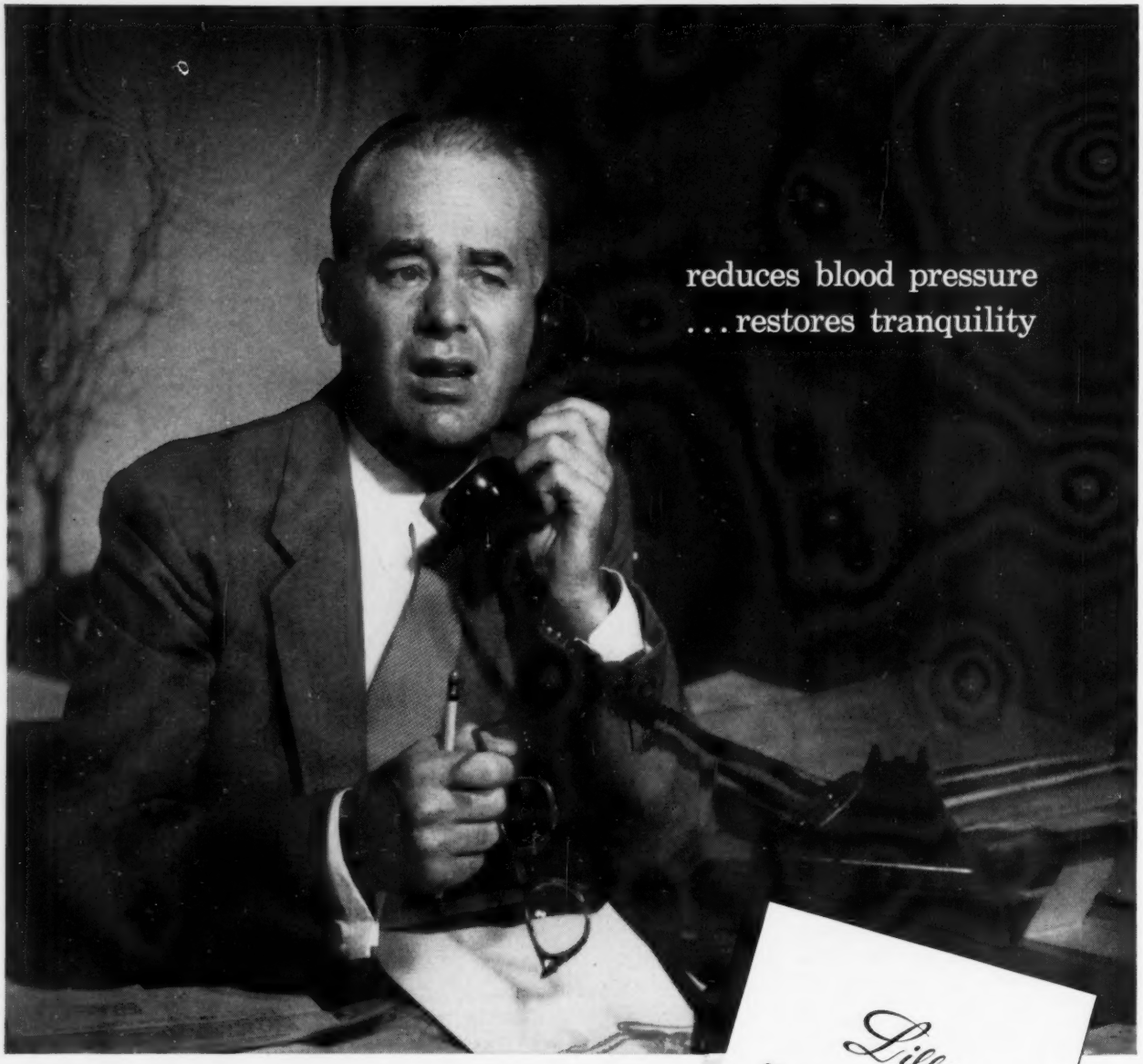

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In anxiety states, nervousness, and the menopause, it restores tranquility and serves as an ideal adjunct to specific therapy.

When more resistant, fixed types of hypertension require 'Provell Maleate' (Protoveratrine A and B Maleates, Lilly), adjunctive treatment with 'Sandril' dissipates the "emotional overlay" and often makes possible effective therapy on a lower dosage schedule of 'Provell Maleate.'

SUPPLIED AS 0.25-mg. scored tablets.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

VOL. 33, NO. 2
FEBRUARY, 1955

Scanning the News

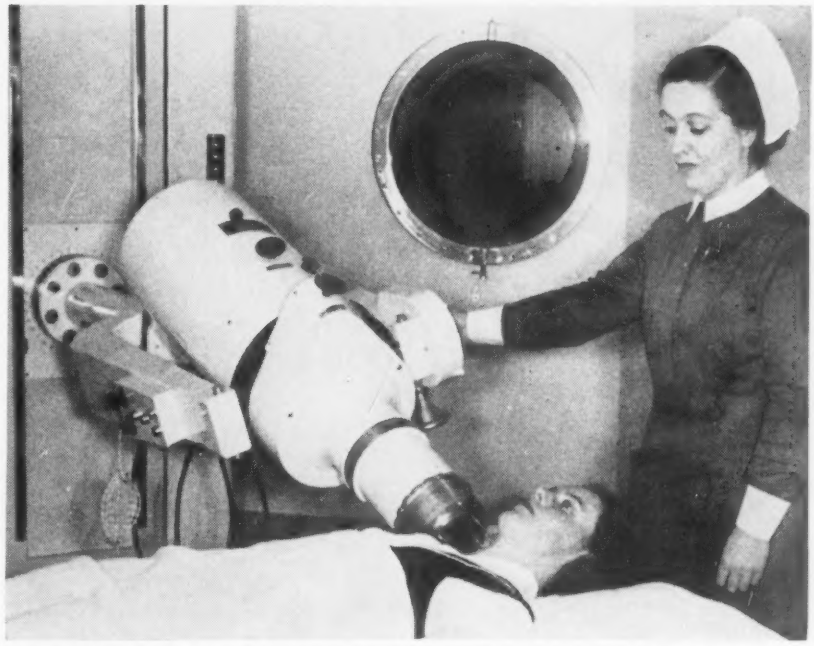
Physicians "Go to School" Via Television

An hour-long television symposium, to be presented February 24, may be a forerunner to televised medical postgraduate courses.

The program, sponsored jointly by the American Academy of General Practice, Kansas City, Mo., and Wyeth Laboratories, Philadelphia, will feature six internationally known medical authorities who will discuss "The Management of Streptococcal Infection and Its Complications." The largest multiple-city closed-circuit television program ever to be staged, it is expected to reach 15,000 physicians in 57 cities. It is the first time the academy has used television to bring postgraduate education to members in all parts of the country.

Speaking on the significance of this television symposium, William B. Hildebrand, M.D., president of the academy, says it is within the realm of possibility that within a few years all physicians participating in postgraduate medical work will "go to school" via this new medium.

The program will originate in CBS television studios, New York City, from 6 to 7 p.m. (EST).



Britain's first telecobalt unit for the treatment of cancer has opened at Bristol General Hospital, Gloucestershire. The unit differs from most of those already in use because uranium instead of the heavier lead has been used for screening off the rays from the cobalt, thus reducing weight of the treatment head to 700 pounds, instead of up to two tons. The unit, shown above, was built by the Department of Engineering at the Universiy of Cambridge, with the Atomic Energy Research Establishment at Harwell serving as advisor.

Substance Found in Tears May be Cancer Weapon

An enzyme contained in tears shows experimental hope as a weapon against cancer, according to two California chemists, Drs. Otto E. Lobstein and S. I. Dulkin of Chem-Tech Laboratories, Beverly Hills.

Tiny amounts of the substance injected directly into cancers in mice caused some of the malignancies to disappear entirely, and significantly prolonged the lives of the diseased animals.

Called lysozyme, the enzyme is an important component of tears and protects the eyes against harmful microbes. It is also normally present in body fluids such as blood and saliva.

Dr. Lobstein and Dr. Dulkin, who reported on the finding at a recent meeting of the American Association for the Advancement of Science, got the lysozyme idea from observing that cancerous humans had more lysozyme in their blood than healthy humans. This suggested, they said, that the human system naturally tries to fight cancer by producing additional lysozymes. So far experimentation has been confined to animals.

Drug from Cobra Venom Relieves Pain

A drug obtained from cobras is being used as a substitute for morphine for relief of severe, protracted pain, David I. Macht, M.D., Mount Sinai Hospital, Baltimore, told members of the American Association for the Advancement of Science at a recent meeting in Berkeley, Calif.

The drug, called cobratoxin, is a purified material separated from other chemicals in the venom of certain Indian and Egyptian cobras. It is relieving pain from cancer and from tic douloureux, an almost unbearable pain caused by a facial nerve ailment, Dr. Macht said. He added that the new drug is not habit forming.

Good Habits Conserve Energy Says Chicago Psychiatrist

Well-formed habits can become the great secret of mental conservation and physical economy, says Chicago psychiatrist William S. Sadler, M.D. The more automatic and habitual you can make details of your daily living, the more your mind will be set free for other matters, he declares.

It is generally agreed, he says, that habits are established by repetition which creates pathways in the nervous system.

To break a bad habit or form a new one demands more than good intentions, Dr. Sadler says. There must be prompt action with the first possible opportunity to act on the resolution seized. Delay only weakens the desire, according to the psychiatrist.

Calendar of Meetings

FEBRUARY

4- 5 AHA Midyear Conference
Palmer House, Chicago

5- 8 Congress on Medical Education and Licensure, Palmer House, Chicago

9-10 National Association of Methodist Hospitals and Homes
Palmer House, Chicago

9-11 American Protestant Hospital Association
Palmer House, Chicago

24-26 AMA National Conference on Rural Health, Schroeder Hotel, Milwaukee

MARCH

1- 4 Chicago Medical Society
Palmer House, Chicago

7-10 Ohio Hospital Association
Netherland Plaza Hotel, Cincinnati

17 Wisconsin State Hospital Association
Milwaukee

21-23 Aero Medical Association
Hotel Statler, Washington, D.C.

24-26 New Mexico Hospital Association
Hilton Hotel, Albuquerque

25-26 American Osteopathic Hospital Association, Eastern Area Institute
Hotel Statler, New York City

28-30 New England Hospital Assembly
Hotel Statler, Boston

28-31 American Academy of General Practice
Hotel Statler, Los Angeles

30 Washington State Hospital Association
Midyear Meeting
Winthrop Hotel, Tacoma

APRIL

12-14 Kentucky Hospital Association
Hotel Seelbach, Louisville

12-14 Texas Hospital Association
Hotel Shamrock, Houston

20-22 Southeastern Hospital Conference
Atlanta Biltmore Hotel, Atlanta

21-22 Carolinas-Virginias Hospital Conference
Hotel Roanoke, Roanoke, Va.

24-29 Fifth Inter-American Congress of Radiology, Washington, D.C.

25-28 Association of Western Hospitals
Civic Auditorium, San Francisco

27-29 Mid-West Hospital Association
Hotel President, Kansas City

MAY

2- 5 Tri-State Hospital Assembly
Palmer House, Chicago

2- 5 National League for Nursing
Kiel Auditorium, St. Louis

11-13 Upper Midwest Hospital Conference
Hotel Nicollet, Minneapolis

16-19 Catholic Hospital Association
Kiel Auditorium, St. Louis

25 Massachusetts Hospital Association
Hotel Statler, Boston

25-27 Middle Atlantic Hospital Assembly
Convention Hall, Atlantic City

JUNE

6-10 American Medical Association
Auditorium, Atlantic City

20-24 American Physical Therapy Association
Hotel Jefferson, St. Louis

29-July 2 American Surgical Trade Association
Ambassador Hotel, Los Angeles

SEPTEMBER

17-19 American College of Hospital Administrators, Atlantic City

19-22 American Hospital Association
Traymore Hotel, Atlantic City

OCTOBER

3- 7 American Association of Medical Record Librarians
LaSalle Hotel, Chicago

13-14 Mississippi Hospital Association
Hotel Buena Vista, Biloxi

19-20 Washington Hospital Association
Davenport Hotel, Spokane

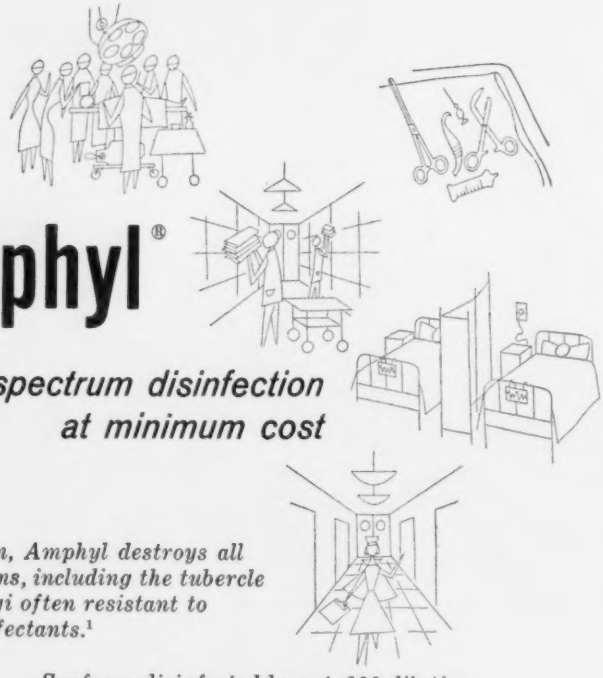
30-31 American Osteopathic Hospital Association, Hotel Statler, Washington, D.C.

NOVEMBER

14-18 American Public Health Association
Municipal Auditorium, Kansas City

19-21 American Surgical Trade Association
Semi-Annual Meeting and Technical Exhibit, Conrad Hilton Hotel, Chicago

29-Dec. 2 AMA Clinical Session
Boston



Amphyl®

broad spectrum disinfection at minimum cost

In 1:200 dilution, Amphyl destroys all common pathogens, including the tubercle bacillus and fungi often resistant to other type disinfectants.[1]

Surfaces disinfected by a 1:200 dilution of Amphyl retain their bactericidal-fungicidal-tuberculocidal potential for as long as a week.[1]

From surgery to routine housekeeping, Amphyl is widely applicable for varied disinfection needs. Due to its high concentration, Amphyl takes minimum storage space and is economical. One gallon, diluted 1:200 as recommended for general utility, will disinfect 140,000 square feet of surface at a cost of approximately 2¼ cents a gallon.

No unpleasant odor. Non-corrosive. Non-irritating.

1. Klarmann, E. G.; Wright, E. S., and Shternov, V. A.. Prolongation of the antibacterial potential of disinfected surfaces, Applied Microbiology 1:19 (Jan.) 1953.

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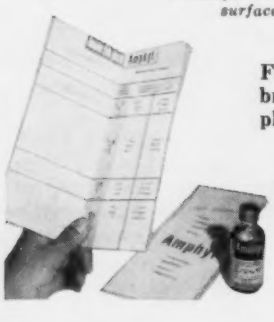

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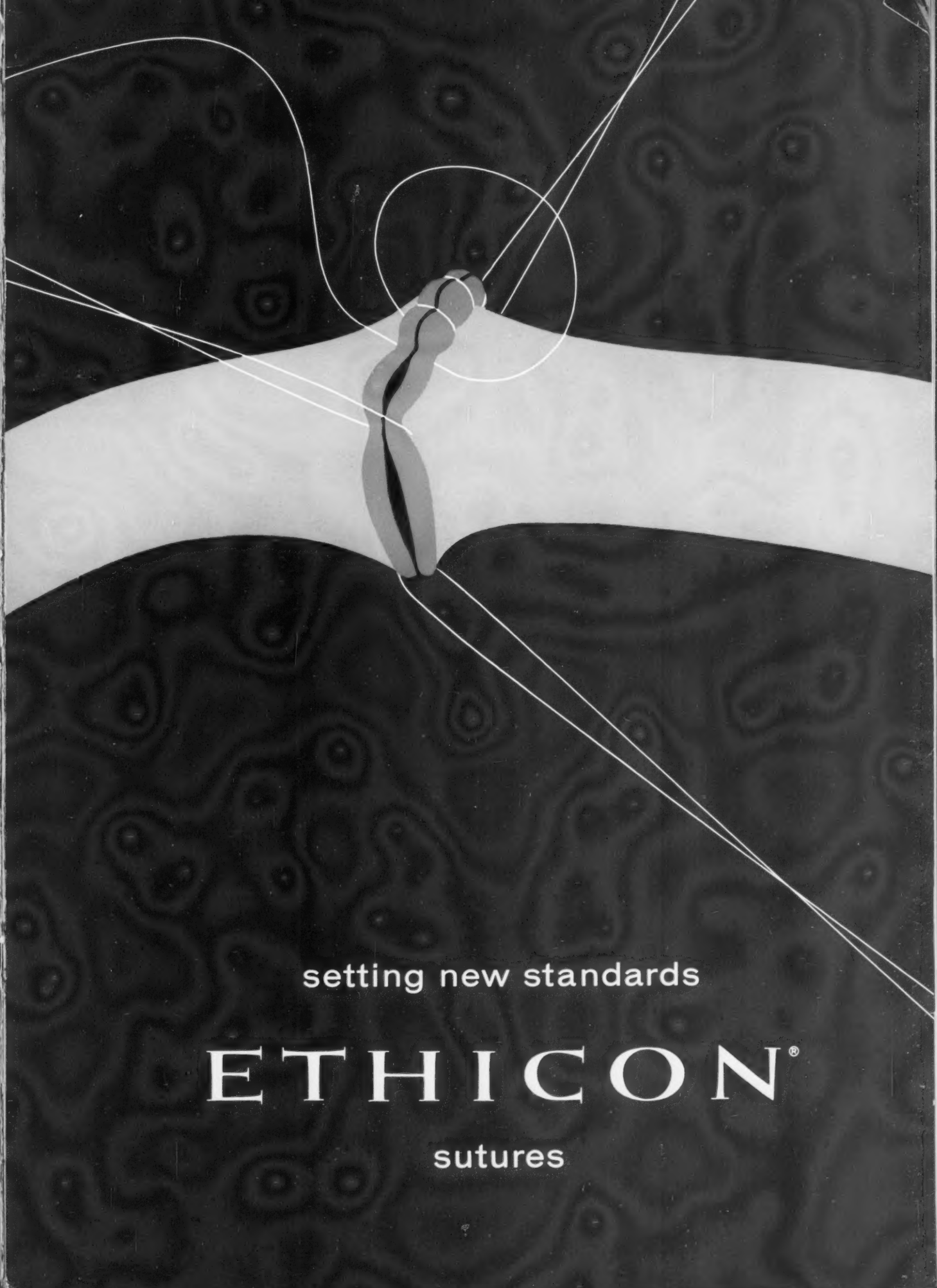

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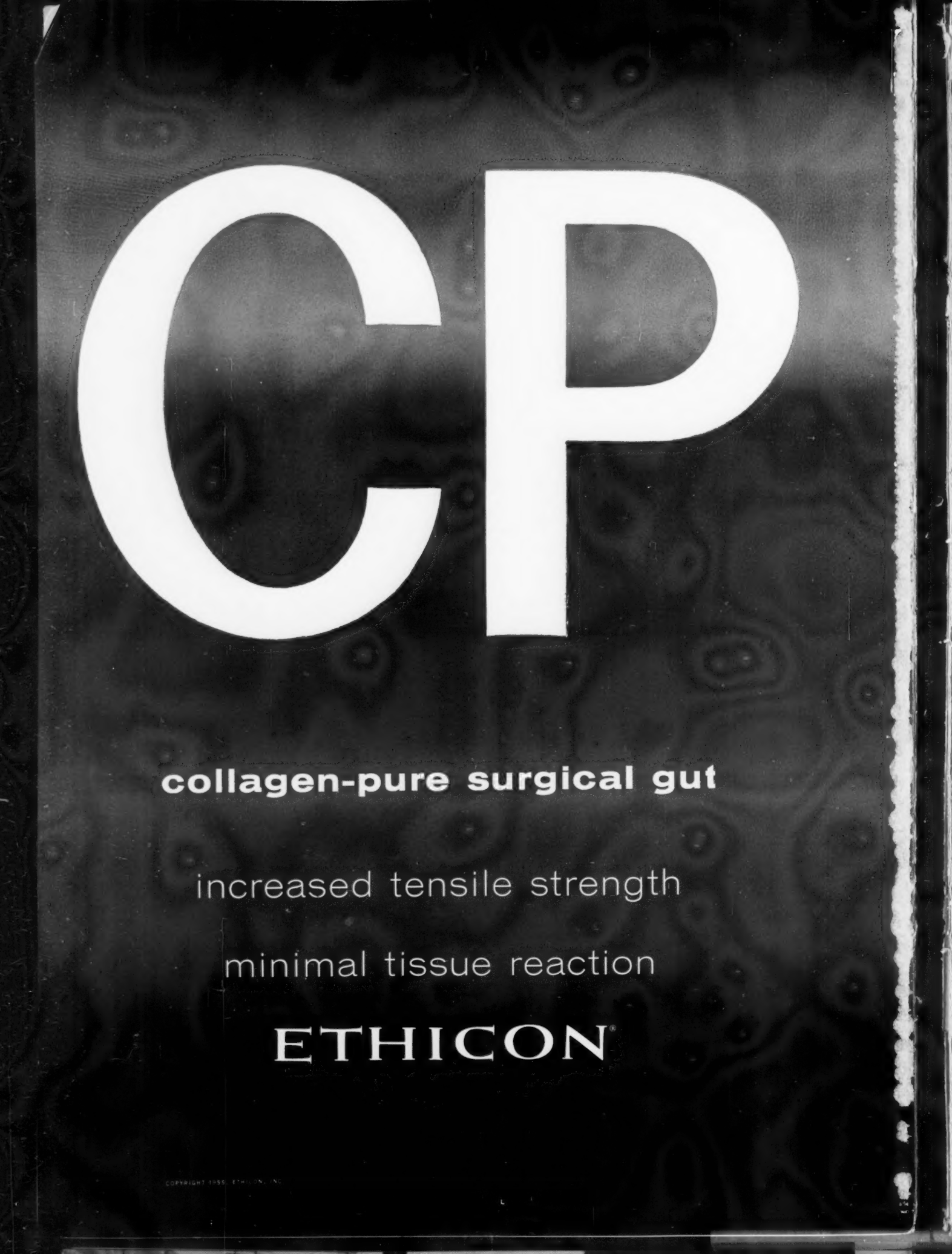

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News Briefs at Press Time

Four Point Plan

Sen. Lister Hill (D., Ala.), new chairman, Senate Labor and Public Welfare Committee, has announced following four-point plan as "an absolute minimum objective for this year:" (1) Construction aid for schools of medicine, dentistry, and nursing; (2) extension of voluntary health insurance to the aged, unemployed, and indigent; (3) further stimulation of medical research, and (4) strengthening of local public health programs, in conjunction with measures designed to increase the national supply of expert public health personnel.

AHA Plans New Survey

New AHA survey is being planned to get up-to-date information on national hospital requirements. Committee, headed by Chairman Dwight Barnett of Columbia University, will outline proposed study, to take inventory of such factors as bed-ratio standards, community needs for hospital beds, Hill-Burton planning, reduction in patient stay, increase in nursing homes, greater utilization of practical nurses.

One objective of survey: to set new requirements criteria for TB, psychiatric, and chronic disease hospitals, measuring resources in services rendered, instead of bed capacities.

New Scholarship Bill

Rep. Charles E. Bennett (D., Fla.) beat administration to the punch by introducing his own military medical scholarship. He also may sponsor measure to authorize establishing a government academy for training military medical officers.

Along same lines, Army and Navy medical departments are concerned about shortage of career medical officers and about present tight ratio of three medical officers to every 1,000 men. Recent reduction of 400,000 in military manpower within next 18 months means proportionate decrease in medical officers.

Reinsurance Bill

Revamped reinsurance bill probably will be sponsored by former chairman Charles A. Wolverton (R., N.J.) of House Commerce Committee.

Hepatitis on Increase

What's happened to concentrated efforts to combat hepatitis, or are cases merely being recognized and reported more often? Cases in 1954 went up more than 50 percent over 1953, according to Public Health Service.

New Color TV Programs

An estimated 60,000 physician-visits will be paid to closed-circuit color television programs at 15 postgraduate medical meetings during 1955, according to Smith, Kline & French Laboratories. The firm made the announcement in conjunction with release of the schedule for its sixth consecutive year of medical color telecasting.

International Congress

The Ninth International Hospital Congress will be held in Lucerne, Switzerland, May 29 through June 3. The Congress, to be combined with a hospitals exhibition, will have as its theme "The Mental Well-Being of Patients in the General Hospital."

During the congress, meetings of the General Assembly of Members of the International Hospital Federation will be held, as well as meetings of the Council of Management and the Executive Committee.

Gordon W. Marshall

The accident.

Small Hospital Geared to Heavy Emergency Load

• It's unusual for a 100-bed hospital to have two emergency rooms, but Marin General Hospital, San Rafael, Calif., does not have the "usual" emergency load for a hospital of its size. Situated just off busy highway U. S. 101 north of San Francisco, the hospital gets about one-third of its emergency room cases from automobile accidents. Domestic accidents account for the rest.

Marin General has an emergency service area which includes approximately 63,000 persons. During a recent 12-month period, 4,711 persons were treated in the emergency suite. Accidents ranged from minor childhood injuries to attempts at self-destruction. Approximately half the cases were brought in by ambulance, and about one-fourth came in under police supervision.

Between 7 and 7:30 a.m. or after 5 p.m.—periods of heavy commuter traffic—are busy hours for the emergency room, says hospital administrator William S. Weeks. So are holiday seasons, of course, and nights of football and basketball games.

A house physician is in charge of the emergency suite

Loading the accident victim into the ambulance.

Arrival at the hospital.

24 hours a day. Four physicians take turns on this duty. Full-scale nursing service is maintained on the a.m. and p.m. shifts, while a "floating" nurse covers the 11 p.m.-7 a.m. shift.

An "on call" list for the emergency room assures prompt, excellent emergency care. The standby physician is ready to supervise and call in any extra help he needs. Ten minutes after a recent auto accident, five nurses and four doctors had arrived at the hospital to care for the 11 victims. This fast response was possible because the personnel lived so close to the hospital.

The well-stocked emergency rooms include anti-venin, rabies serum, antibiotics, medications for regurgitation, and positive pressure resuscitation equipment. Occasionally the ambulance may move equipment to the scene of the accident.

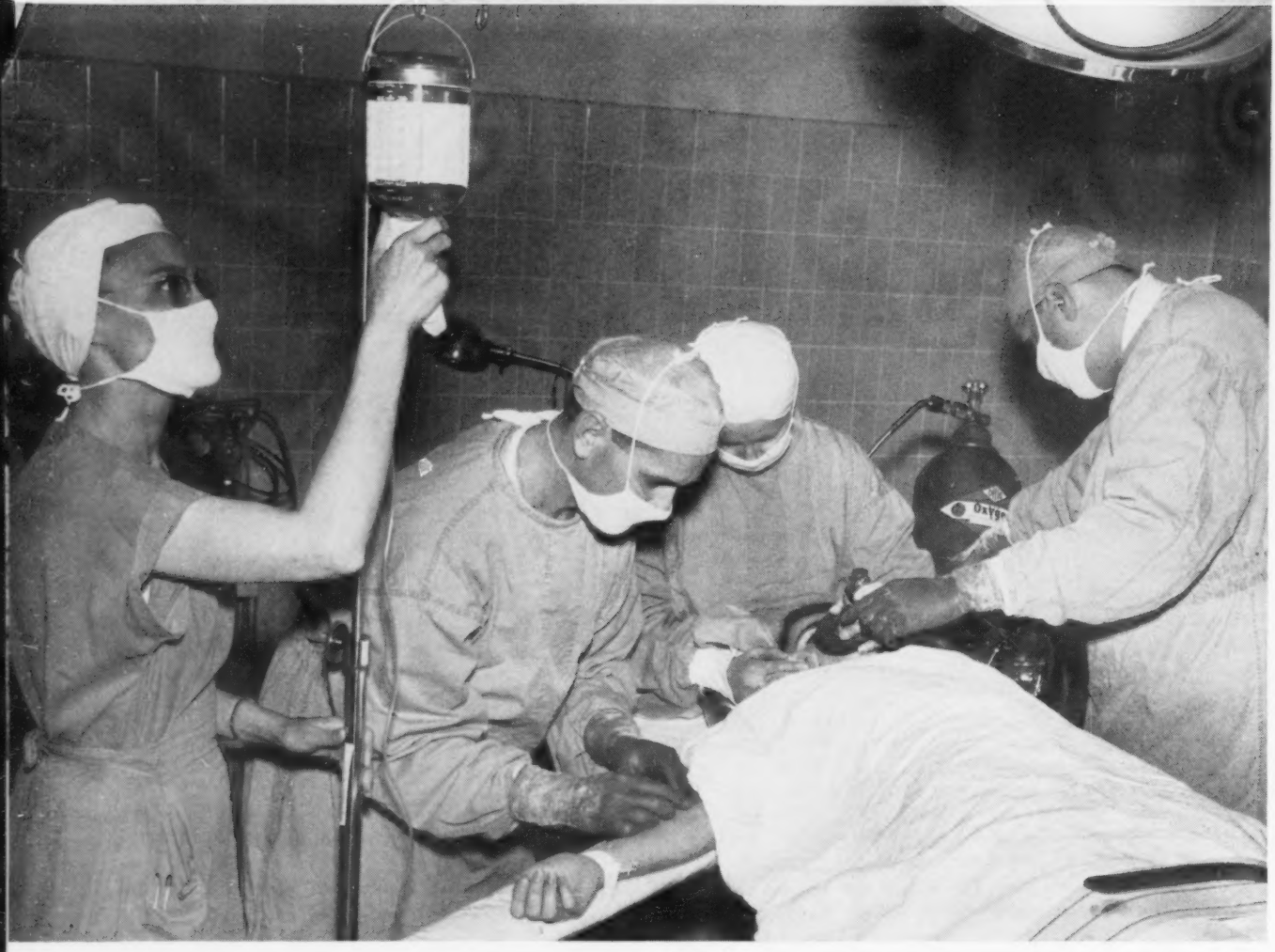
A connecting room between the two emergency rooms is used as a utility and clean-up area and for storing antibiotics.

No surgery is performed in the emergency room, which is on the ground floor, because the surgical suite is so close (on the second floor) that it is just as easy to take cases requiring surgery up there.

(Continued on next page)

Checking the patient's blood pressure.

The x-ray.



Surgery.

HEAVY EMERGENCY LOAD continued

A room across from the suite, near the emergency entrance, is a "minimum security" room, for alcoholic or psychiatric patients. The room can be stripped except for a foam rubber mattress when a violent patient is brought in. The hospital has two such rooms on each floor.

Emergency room cases give a strong indication of the way hospital services are going, Mr. Weeks believes. The increase in the number of childhood accidents treated, he points out, is evidence of the steady growth of the community and the inclusion, in that growth, of more young families.

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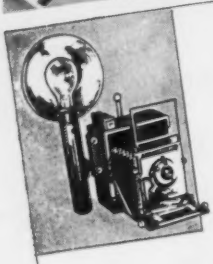
Representatives of various Indian pueblos came to official dedication to celebrate opening of hospital which will aid their people. L. to r.: Bob Allen, Navajo from Farmington; Juanito Medina, governor of Zia; Lawrence Calabaza, lieutenant governor, Santo Domingo; Augustin Aguilar, interpreter, Santo Domingo; Abel Paisano, Laguna pueblo and ex-trustee; Tomasito Tenorio, governor of Santo Domingo; Ambrosio Abeita, lieutenant governor, Isleta; John Bird, spokesman, Santo Domingo; and Isidro Abeita, secretary of the council from Isleta.



Hospital Topics ..... Goes Calling

. . . on James E. Jenkins
Administrator
Bernalillo County-Indian Hospital
Albuquerque, N. Mex.

Administrator James E. Jenkins (l.), with Glen L. Emmons, Commissioner of Indian Affairs, and Don E. Woodward, president, hospital board of trustees, at dedication ceremony.

Back row (l. to r.): Costillo Vallo, governor, Acoma pueblo; John Bird; Glen L. Emmons; and Lawrence Calabaza. Front row (l. to r.): Diego Abeita, Isleta pueblo, member, board of trustees; Augustin Aguilar; Carlos Jojola, governor, Isleta pueblo; Tomasito Tenorio; and Ambrosio Abeita, lieutenant governor of Isleta pueblo.

Above: Miss Chewini wraps packs in all-stainless steel central supply room, conveniently situated right next to the operating room suite, across from the recovery unit. At right: Virginia Holste, R. N., nurse in charge of central supply, at distilled water tap, in adjacent room. Water is bottled there, then sterilized. Department staff includes two R. N.'s, three aides.

● A unique cooperative arrangement is providing better hospital care to the Indians of northern New Mexico and to indigent patients in Bernalillo County.

The county and the U.S. Bureau of Indian Affairs joined forces to build the $3,250,000 Bernalillo County-Indian Hospital, which opened last fall. Cost of construction was divided almost equally between them—the county paying $1,750,000 and the Bureau, $1,500,000.

Operation of the hospital, built on county property, is the responsibility of the county. Indian patients are cared for under terms of a contract between the county and the Bureau, which provides that a minimum of 100 beds must be available for Indian patients. The Bureau will pay on a per diem cost basis for Indians hospitalized, and guarantees payment for 80 percent of the beds, whether they are used or not. After these contract specifications have been met, the rest of the 211 beds are available for indigent patients.

Administration of the hospital will be controlled by a board of trustees appointed for five-year overlapping terms by the board of county commissioners. The trustees are Don E. Woodward, president; Arthur D. Ortega, vice-president; Charles C. Brunacini, secretary-treasurer; Diego Abeita and Ralph Jones.

When the hospital was officially dedicated, leaders of the pueblos turned out to celebrate the occasion. Since the opening day—October 27—business has been booming. Administrator Jenkins, expecting a slow start, was somewhat overwhelmed by the rapid rise in patient census. The hospital, on opening day, received 26 patients who were transferred from a nearby Indian hospital. Less than four weeks later, the census had climbed to 136.

More than 900 were treated in the emergency room in the first four weeks. The operating rooms have been in use since the first day, when the staff had to work with borrowed instruments.

Patients during the first few weeks included a high percentage of children, acute medical patients, and victims of malnutrition.

The hospital plans to establish a 26-bed psychiatric unit on the second floor, just off the employees' cafeteria and kitchen, when the needed staff members are available. At present those beds are used for overflow and convalescent

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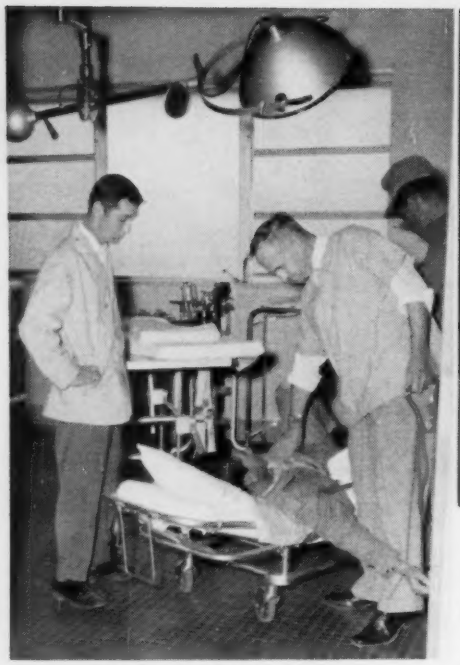
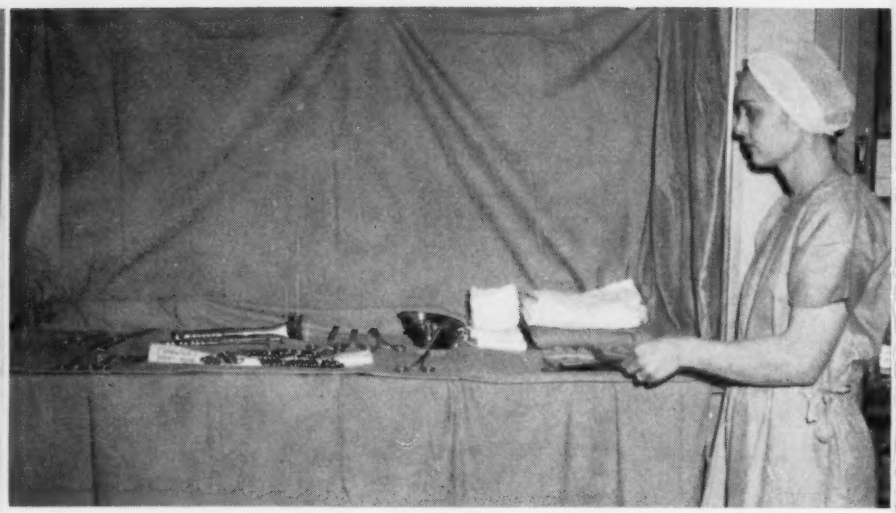
Girl Scout "Bluebirds" proudly present stuffed animals they made to Mr. Jenkins, to be used by children in hospital's pediatric ward—one of the busiest units in the hospital.





Left: Emergency room staff quiets its latest arrival. Group in waiting-room outside always busy department often includes Indians dressed in colorful tribal garb. Above: Mrs. Rosemary Harrison, assistant operating room supervisor, at recessed area designed to replace large movable steel table for sterile area in operating room. Idea was brought from Sweden by W. R. Lovelace, II, M. D., Albuquerque surgeon. See page 66 for picture of hospital's recovery unit.

TOPICS GOES CALLING continued

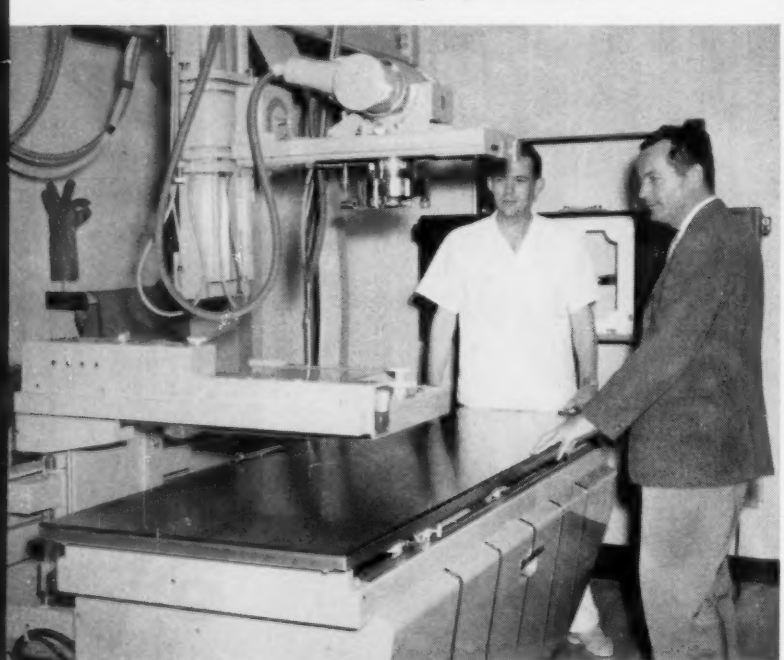
patients, and psychiatric patients are on the medical floor.

The hospital's recovery room unit, instead of being in a separate room, is in a wide hall opposite the operating room supervisor's desk. A picture of the unit appears on page 66.

The 132 members of the medical staff represent most of the practicing physicians in Albuquerque. Two surgical residents are on affiliation from the Veterans Administration. Four doctors cover the admitting service full-time, because many patients admitted have not seen a doctor before, and tentative diagnoses must be made.

Mr. Jenkins, an Albuquerque native, came back to take charge of his home town's new hospital after completing his training in hospital administration at Columbia University and working at Roosevelt Hospital, New York City, and Herkimer Memorial Hospital, Herkimer, N. Y.

Above: Hospital has some two-bed wards which can be used as isolation units. Connecting utility room has sterilizer and all necessary equipment, so that nurse doesn't have to leave unit. Mrs. Zelda June Bell, R. N., staff nurse, obstetrical department, is shown here in compact utility room.



Left: Leslie Wilson (l.), chief x-ray technician, answers Mr. Jenkins' questions about the latest in x-ray equipment and treatment.

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Make Your Accounting System a Management Tool

By John P. Garrison
Assistant Superintendent
Highland-Alameda County Hospital
Oakland, Calif.

An accounting system, its resultant financial statements, and the construction for interpretation with other factors, should be designed for the administrator, not the administrator for the system. If your system is not providing you with a guide for administrative policy, it is simply wasting your money. If it only serves tradition or keeps the board and the auditors happy, you should assign your business office personnel to some useful task, like rolling bandages.

We neglect, sometimes, to take full advantage of the factors expressed in a financial statement as management tools. Although I do not intend to discuss here the design of accounting systems, certain fundamentals that you in management should observe, in order to use the results intelligently for successful operation of your business, are:

(1) State the facts concerning all accounts.
(2) Coordinate these facts for easy interpretation.
(3) Get at the truth simply and express it clearly.
(4) Be capable of thorough analysis.
(5) Relate the results to other pertinent factors.

A good system is a prerequisite to management control.

We must start the design of the system by asking, "What do we want to know?" Simplicity, of course, is essential to any good design, but other conditions necessary to make effective analysis possible are:

(1) Logical construction, without which no satisfactory conclusions can be drawn. Here is the place for a uniform accounting system.

(2) Consistent classifications and arrangement over a period of time.

(3) Listing of results and units of measure under the same classifications.

With the observance of these fundamentals, use of the financial statement then depends largely upon the knowledge of the individual, his technical training, and his experience and ability to recognize factors important to management control. What are some of these factors?

Balance Sheet

We, as hospital people, tend to pass over the balance sheet in favor of the operating statement. Yet the balance sheet demonstrates the financial strength of any business, and we may well consider some of business' standards.

Fixed Capital

How many of us know exactly how much our business is worth? Do we really know how much is invested? These answers are easily obtained if our accounting has been consistent. Fixed capital states the funds invested in properties that are more or less inactive, except as the fixed space and equipment used for delivery of services.

Method of determining:

Value of fixed plant and major equipment (net)	$
Investments—long-term	
Total	$
Less: Long-term indebtedness	
Fixed Capital	$

This is an important factor in the analysis of any enterprise. By the net value of plant we mean the original cost less accrued depreciation.

Working Capital

We should be alert to funds that are immediately available, whether we operate on our own revenues or lose their identity by returning them to general funds. Commerce uses the difference between current assets and liabilities as the measure of capital being used actively, or the ratio of funds immediately available.

Method:

Current assets	$
Deferred charges	
Total	$
Less: Current liabilities	
Working Capital	$

The amount of working capital represents the funds immediately available for current operations. Like fixed capital, it is a valuable factor for comparisons.

Reserve Strength

This represents the value of all your assets, omitting deferred charges in excess of current liabilities, and is of special interest to anyone issuing or underwriting long-term obligations.

Method:

Current assets	$
Investments—long-term	
Value of plant (net)	
Total	$
Less: Current liabilities	
Reserve Strength	$

Liquid Strength

This represents the total assets that can be changed into cash in a short time, under normal conditions. This total

(Continued on page 20)

Mr. Garrison

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is of special interest to your banker or your finance committee, as it is the sum immediately available to meet current liabilities. Notes receivable having long-term maturities should not be included:

Method:

Cash	$
Notes receivable (short-term)	
Accounts receivable	
Marketable inventories	
Liquid Strength	$

Owned or Invested Capital

This is the equity of the owners of any business, or the difference between assets and liabilities, or, in the case of a corporation, the capital stock plus surplus. This factor is very important if you are negotiating loans.

Borrowed Capital

Borrowed capital—one of the tests of financial strength—is that part of funds obtained from sources outside your own business. It is important that the elements of this factor be considered in their relationship to the pledged security.

Method:

Current liabilities	$
Long-term debt	
Borrowed Capital	$

The enumerated factors represent the strength of management and are the earmarks of good policy to others as well. The factors themselves provide comparisons. By summarizing them, with their amounts, we can see their relationships. For example, for every dollar of invested capital, what unit is employed as fixed capital, and what portion of the unit represents working capital? These comparisons will provide the ratio between capital invested in plant and that being used for current operation.

Other questions you might ask are:

What is the ratio between invested and borrowed capital?

What is the ratio between reserve strength and long-term obligations?

How much in assets have you for each unit of invested capital?

What is the unit ratio between liquid strength and current liabilities?

Since it is obvious that we can use ratios as a management tool, we should consider some of the standard comparisons established by banks, credit men, and commercial enterprise as a uniform method of testing any business. These ratios are in two principal divisions: static and velocity ratios.

STATIC RATIOS

Some of the ratios just suggested are static in that they represent the condition of business as of the date of the balance sheet. They should be used as an index to the soundness of management.

Some of the basic ratios are:

Current Assets to Current Liabilities

The "Working Capital" ratio. A ratio of 2 to 1 is considered acceptable, and anything above that, an improvement of position. This ratio should be watched closely, for it is the index to the operation of a business. Any marked increases or decreases from the established standard should be analyzed carefully.

In connection with this ratio, an application of funds statement is valuable. While it is not a ratio in the strict sense, it does tell:

(1) The sources from which capital is acquired and how much comes from each source.

(2) The purpose for which working capital has been expended and the amount spent for each purpose.

(3) The increase or decrease in working capital and the reasons for such changes.

VELOCITY RATIOS

These are the "How did we get that way?" ratios, which show the activity of a business during a stated period of time, usually a month or a year. They might also be considered qualitative analysis. Some of the more commonly used ones are:

Accounts Receivable to Revenues. This ratio and its applications provide the means of determining the rapidity of collections; determine the efficiency of your determination of full, part-pay, and charity accounts; provide an index to the efficiency of your collection procedures, and tell the rate of turnover of accounts.

Operating Expenses to Inventories. Under normal conditions, this ratio should be fairly constant, and is therefore a good index of efficient operation from period to period.

Inventory Turnover. This is, generally speaking, a measurement of the utilization of funds. As an example, if a business turns over its inventories six times a year, the maximum stores required as of any given date would be a two-months' supply. Obviously, the more times the inventory can be turned over, the fewer unproductive dollars are tied up in stock. A high turnover rate is an indication of good purchasing.

If the inventory becomes less than the established ratio, there may be danger of trying to work on too close a margin.

Revenue to Owned Capital. This ratio determines how efficiently your capital investment is being employed.

There are many other relationships that can be used for management purposes, other than the common unit costs, such as patient days, clinic visits, meals, and others. All of these are useful because they can be built up over a period of time, so that we may know the critical points and what variations from previous experience really mean. Some of them are:

(1) Percent of bad debt loss.
(2) Percent of discounts and allowances.
(3) Percent of deductions from gross income.
(4) Amount of perpetual inventory adjustment.
(5) Ratio of cash discounts to purchases.
(6) Ratios of income to expense in special departments, such as operating rooms, delivery rooms, laboratory, etc.
(7) Operating income per patient per day.
(8) Raw food cost per meal.
(9) Served food cost per meal.
(10) Ratio of patient days to employee hours by departments or job classifications.
(11) Labor turnover by departments and job classifications.

RELATED DATA

It is not my intention to evaluate standard units of cost suggested by the uniform classification of accounts, except to extend some of their applications and interpretation. Much related data can be used.

Price Index. Determination of the purchasing power of the expended dollar will answer some questions like, "Has the value of our operations increased, or just the expended dollars per unit? Comparison of values with those of 15 years ago may give an insight into the comparative efficiency of your operations which book dollars alone will not do.

This comparison, which applies to all units of cost, is easily made. First, develop your own index and the pur-

(Continued on page 22)

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chasing value of a dollar for your area. The source of the Consumer's Price Index is the Bureau of Labor Statistics, Department of Labor, in the major city nearest you. It is suggested that you use the 1935-39 equals 100 base, as it provides the longest trend available by years. There is also a 1947-49 average index available.

The purchasing value of the dollar for each year is determined by dividing 100 by the index for that year.

The cost per unit stated as the purchasing value of the dollar for a specific year is determined by multiplying the book value unit cost by the purchasing value of the dollar for that year.

These tables sometimes produce some startling results. An example is the cost per emergency visit.

	Book Value	Purchasing Value
1935-39 average	$2.62	$2.62
1953	5.27	2.16

It is evident that the emergency department operated more efficiently in terms of value received, even though more book dollars were expended.

In addition to pure unit costs, other related information that should be of interest, because these factors reduce to dollars in final analysis, includes:

Actual Availability and Utilization of Each Bed

(1) Availability—the number of times during a year that a given patient bed is available for occupancy. Calendar days in a year divided by the average length of stay equals the days the bed is available.

(2) Utilization—the number of days during a year that the same bed is actually used. The availability rate in days times the percentage of occupancy equals the utilization in days.

Comparison of the two rates provides an index into the effectiveness of admitting and discharge procedures during the year. This can also be done on a monthly basis.

There are many methods of presentation, determination, and interpretation of information, a few of which are:

(1) Presentation—in dollars, units of cost, percentages, ratios, averages, both in values, numerically and graphically.

(2) Determination
   a. The arithmetic mean—the simplest form of average.
   b. The mode—the most frequent or common value in a group of figures.
   c. The median—middle item of a series arranged in sequence.

(3) Interpretation
   a. Seasonal fluctuations. Do you have high points and dips occurring at approximately the same time each year?
   b. Trends. What is the direction of movement over longer periods of time?
   c. Cycles. These are time series which often will indicate wavelike increases or decreases. They may occur frequently enough to be of value in forecasting.

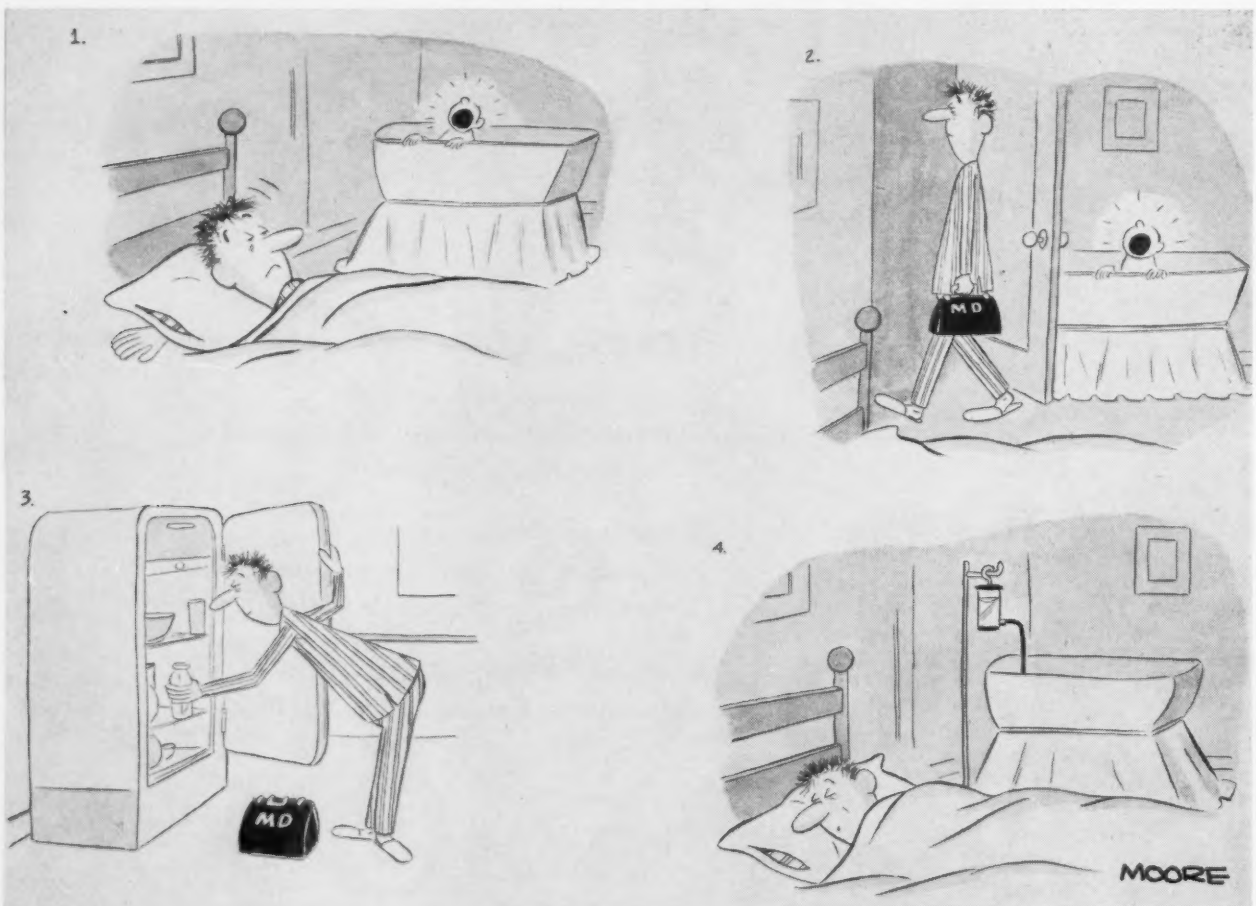
Finally, here are some questions to stimulate your thinking in using data at hand:

Has your employee-patient ratio changed over a period of years? If so, why?

What is the change in the percentage relationship of salaries and other operating expenses to total cost? Why?

Are you comparing your actual nursing hours with national standards to forecast your personnel needs?

What is the cost per patient hour compared with the minimum wage level in your community?



Association of Military Surgeons

Has 61st Annual Meeting

Gen. Martin

● Military medicine, and medicine in general as it relates to Federal services, commanded the attention of representatives from all branches of military medicine from all over the country at the 61st convention of the Association of Military Surgeons of the United States, held recently in Washington, D.C. Also present were a number of prominent military figures and official delegates from foreign countries.

New officers elected by the association for 1955 are: Maj. Gen. Joseph I. Martin, MC, USA, president; Rear Admiral John Q. Owsley, MC, USN, first vice-president; Col. Amos R. Kontz, MC, Maryland National Guard, second vice-president; Arden Freer, M.D. (Col., USA, Ret.), third vice-president; Brig. Gen. H. H. Twitchell, USAF (MC), fourth vice-president; Maj. Gen. Wallace H. Graham, USAFR (MC), fifth vice-president; Col. Robert E. Bitner, MC, USA, Ret., secretary-editor; and Stuart E. Womeldorph, D.C.I., executive secretary.

Adm. Owsley

The following are abstracts of two of the papers presented at the meeting.

Use of the Newer Antibiotics

Monroe J. Romansky, M.D., Department of Medicine, George Washington University School of Medicine, Washington, D.C., and the George Washington University Medical Division, District of Columbia General Hospital, Washington, D.C.—The two most recent antibiotics are tetracycline (Achromycin, Tetracyn) and erythromycin (Erythrocin, Ilotycin). Tetracycline functions essentially in the same manner as chlortetracycline (Aureomycin) and oxytetracycline (Terramycin), with its main features being better absorption and considerably less side reaction.

Col. Freer

Erythromycin is well absorbed orally and can be given intravenously and intramuscularly. It has essentially the same bacterial spectrum as penicillin, with the added advantage of a definite effect on the Hemophilus influenzae and, in addition, generally having an effect on those micro-organisms which are resistant as well as sensitive (particularly the hemolytic staphylococcus aureus) to penicillin or the other antibiotics.

On the basis of available information, these recommendations are in order:

Penicillin should not be given to patients in a comatose state nor those unable to give an adequate history. Other antibiotics, in particular erythromycin, which have the same satisfactory effect should be used.

Individuals sensitive to penicillin should be aware of its meaning and should carry identification with this information.

Cortisone should be used with caution in the presence of infectious disease, or if the possibility of infection exists. Prophylactic chemotherapy in these circumstances should be maximum, and blood cultures should be taken periodically.

Intra-Oral Radiographic Exposures As a Case-Finding Procedure

Gen. Twitchell

Wesley O. Young, D.M.D., M.P.H., Senior Assistant Dental Surgeon (R), Division of Dental Resources; and Walter J. Pelton, D.D.S., M.S.P.H., Dental Director, Chief, Division of Dental Resources, both of Public Health Service, U.S. Department of Health, Education, and Welfare, Washington, D.C.—Two sets of radiographs were taken on 50 patients—a conventional 14-film radiographic examination, and a special set of six radiographs. The six-film sets of radiographs included a No. 2 periapical film on the upper and lower incisor areas, and four No. 3 bite-wing films used to obtain periapical views of the bicuspid and molar areas.

The two sets of radiographs were read and recorded independently. An attempt was made to measure the area covered by the two types of examinations. A record was made of (1) the number of teeth observed in which at least three-fourths of the tooth was shown without distortion; (2) the number of teeth in which the lamina dura could be traced over the apical area; and (3) the number of alveolar crests that could be seen.

(Continued on page 80)

Gen. Graham

when resistance to other antibiotics develops...

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References

(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285. (2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* 91: 143, 1953.

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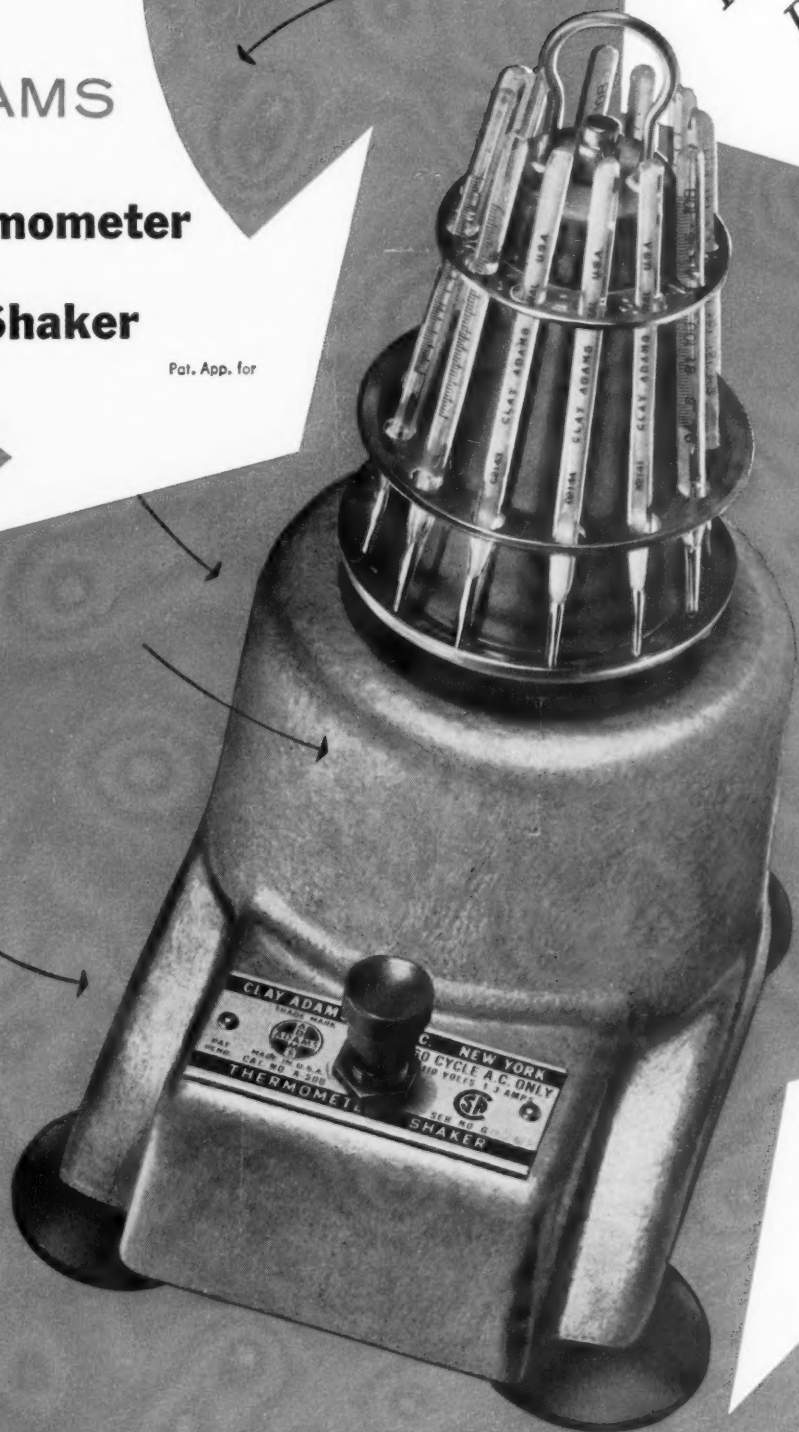

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Dermatologists Meet in Chicago

• The 13th annual meeting of the American Academy of Dermatology and Syphilology was held recently at the Palmer House, Chicago. The following are abstracts of some of the important papers presented during the six-day session.

X-Ray Therapy of Hemangioma

Wesley W. Wilson, M.D., Tampa, Fla.—Birthmarks known medically as hemangiomas—a growth of dilated blood vessels—should be given early treatment, rather than waiting to see if they will disappear in a few years. It is wiser that the lesion be removed slowly, rendering a superior cosmetic result. Low voltage x-ray therapy, given in conservative dosage, is an effective means of treating many of the hemangiomas.

In a group of 200 infants treated with low voltage x-ray, 24 percent received their first treatment before they were six weeks old; 58 percent before seven months, and 18 percent before 13 months. The younger the infant, the less therapy was required to produce a change. In the youngest infants, most needed only three treatments. Older babies usually required from four to five treatments.

Twenty-eight patients did not begin treatment until moderately advanced secondary infection had already appeared. In these patients a poorer cosmetic result was obtained because of extensive tissue destruction by ulceration.

Inoculation of Treponema Pallida in Man

John C. Cutler, M.D., Senior Surgeon and Acting Chief, Venereal Disease Program, U.S. Public Health Service; Evan W. Thomas, M.D., Professor of Clinical Medicine, New York University College of Medicine, New York City; Lopo De Mello, M.D., Venereal Disease Consultant, New York State Department of Health; and Bernard I. Kaplan, M.D., New York State Department of Correction, Sing Sing Penitentiary, Ossining, N.Y.—A 15-month study conducted at Sing Sing penitentiary established conclusive evidence that significant immunity to syphilis in man develops after treatment by penicillin. The study involved 62 human volunteers infected by inoculation with syphilis.

An injection of killed syphilis organisms apparently protected part of the volunteers, who previously had syphilis, from being infected a second time when inoculated by live organisms, suggesting the possibility that a vaccine might be developed to immunize against syphilis.

Silica Granuloma of the Skin

Ervin Epstein, M.D., Assistant Clinical Professor of Medicine (Dermatology), Stanford University, San Francisco; and Rees B. Rees, M.D., Associate Clinical Professor of Dermatology, University of California Medical School, San Francisco—Twelve years after an automobile accident in which he received cuts in his left cheek from a broken windshield, a 50-year old patient developed a severe granuloma (a grainy-like growth). A biopsy done by the crime laboratory of the University of California showed that the crystals in giant-cells were silica. This was caused by the dissolving of the glass by the tissue fluids.

The patient was treated with cortisone. As the lesion healed, the silica crystals were engulfed by structures called Schaumann bodies and they were carried away from the tissue. This explains the lack of recurrence.

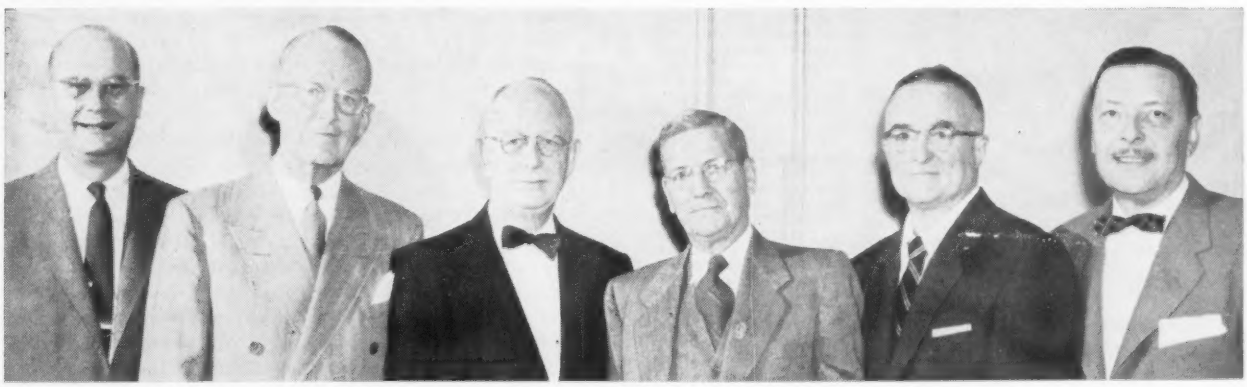
This is the first known recorded case of silica granuloma, due to glass, which was treated and cured by cortisone. It would indicate that silica granuloma is the only known condition that is cured, rather than suppressed, by cortisone. It is also the first time that the importance of Schaumann bodies in the mechanism of cure has been reported.

Treatment of Xanthomas

Frederick Urbach, M.D., Associate Chief, Cancer Research (Dermatology), Rosewell Park Memorial Institute, Buffalo, N.Y.—Experimentation with low fat diets in an attempt to treat xanthomatoses indicated that: (1) restriction of dietary cholesterol alone has no significant effect on human blood serum cholesterol levels; (2) restriction of dietary cholesterol and of animal fats has only an occasional effect on serum cholesterol levels, particularly if the vegetable fat intake is increased; (3) restriction of dietary cholesterol and of all fat (animal and vegetable) seems to have a profound effect on serum cholesterol levels of normal and hypercholesteremic subjects, provided that the total daily fat intake is limited to 25 grams or less; (4) experimentally induced atherosclerosis (a type of arteriosclerosis) in animals, and perhaps seven spontaneous human atherosclerosis, seems to be reversible, at least to a certain degree.

The objective improvement of symptoms known to be due to atherosclerotic disease of important blood vessels suggests the possibility that atheromatous deposits in humans may be reabsorbed under the influence of a low fat, low cholesterol diet.

New and outgoing officers are (l. to r.): Robert R. Kierland, M.D., Rochester, Minn., assistant secretary-treasurer; Carroll S. Wright, M.D., Philadelphia, vice president; Arthur C. Curtis, M.D., Ann Arbor, Mich., president; Fred D. Weidman, M.D., Philadelphia, outgoing president; John F. Madden, M.D., St. Paul, Minn., outgoing vice president; and James R. Webster, M.D., Chicago, secretary-treasurer.



Why Keep Rate Discrimination?

By Lloyd W. Starks
Controller
Middlesex Memorial Hospital
Middletown, Conn.

MANY HOSPITALS TODAY classify their patients as private, semi-private, or ward, basing their room rates on the fact that a room has a single accommodation or a multiple accommodation, regardless of the desirability of its location, and on the fact that private and semi-private patients are treated by their own doctors, while those in the wards are cared for by the various services. Special services are also charged according to the accommodation on the same basis.

Why? Because it has long been the policy to have a premium rate for the private patient to make up the loss for the lower charge to the ward patients, assuming that the semi-private rates approximate the cost of operations.

Maintaining rate schedules for these classifications alone is a problem. The work required in the business office to determine first the classification and then the rate for the services rendered, is a time-consuming operation. The difficulties involved in explaining these rates to the responsible parties create a public relations problem, especially if the classification is changed for some reason during the patient's hospitalization. For instance, suppose that a patient is admitted to the ward service, but subsequent information reveals that a third party is responsible for his financial care, and that the doctor can also be reimbursed. Under the by-laws of many hospitals this would not be possible, if the patient remained a ward case. The adjustment of the hospital account resulting from this reclassification also adds to the front office's problems.

A SOLUTION

To eliminate these conditions, the Middlesex Memorial Hospital has discontinued the practice of classifying patients as private, semi-private, or ward. We use instead the terms non-service and service. The non-service patient is under the care of his own doctor, and the service patient is cared for by the various medical services of the hospital.

Room rates are based on the desirability of the location of the room—not necessarily on the number of beds in a room. This means that a non-service patient can be placed in the lowest room rate area if he feels his financial situation requires it, yet be under the care of his own doctor. This practice alone has eliminated many of the public relations problems encountered prior to this program.

ONE RATE FOR SPECIAL SERVICES

It is generally acknowledged that it does not cost the hospital any more or less to render a special service to a patient in a single bed room or a ward area. Therefore, we have only one rate for special services rendered to a patient. This eliminates the necessity of first classifying a patient before determining the charge for the services. It also makes the explanation easier, and more readily accepted by the public.

With these practices in effect, each patient's account has been accumulated on the same basis, regardless of classification, with only the room rate varying according to the patient's choice of location. It is at this time that consideration is given the service or ward patient.

The Connecticut Hospital Association for a number of years has been sponsoring a uniform cost program under which the hospitals of the state operate. Each year the costs of room service and special services are established under this program, and from this cost analysis we arrive at the basis used for determining the charge to the service patient.

We feel that any hospital should be in a position to obtain the cost of hospital services rendered to a patient whenever possible. Also, in the Public Act of the State Legislature of Connecticut, under which the state reimburses hospitals for services rendered patients under their various programs, the following is noted in part: "Nothing contained herein shall authorize a payment by the State to any such hospital in excess of the charges made by such hospital for comparable services to the general public or to any municipality or in connection with services rendered under the workmen's compensation act or in connection with any hospital service corporation or medical service corporation."

SIMPLIFIES DETAIL WORK

With these facts in mind and with the establishment of a daily cost under a uniform cost analysis program, it is our policy to adjust the service patient's account automatically to the established daily cost, times the number of days stay or the actual amount, whichever is lower. In addition, the credit officer can take the account and recommend further assistance, such as free service, the application of free bed funds, and any other means at his disposal if he feels the patient is entitled to additional assistance.

This program, now well established after several years' operation, has simplified the detail in the business office, is easier to explain and consequently more readily understood by the public. More important, it eliminates discrimination of charges to patients, yet assures the hospital a fair return for its services on a realistic basis.

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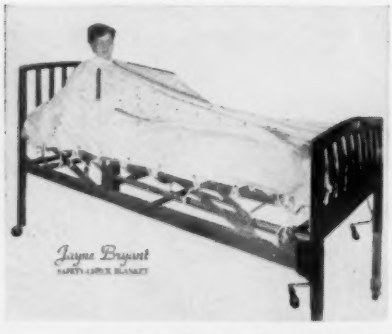

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The Responsibility of Small Hospitals Without Pharmacists

By W. H. Lang
Chief Pharmacist
Kent County Memorial Hospital
Warwick, R. I.

THE SMALL HOSPITAL is expected to maintain the same services as a large hospital, without always being able to afford the facilities and competent department heads. It must maintain the services of larger hospitals because it owes the same obligation to its patients to give them the best medical care possible, economically, legally, and morally. Then, too, in order to gain proper accreditation, it must maintain certain minimum standards. To the small hospital this is no small problem.

How many hospitals without a pharmacy are in existence? Nationally, out of 2,849 hospitals with under 25 to 99 beds, only 749 have pharmacies. Of 5,907 hospitals in the United States, only 3,065 are reported to have pharmacies. These figures are incomplete because they report only whether a pharmacy exists, not whether a pharmacist is on the hospital staff. However, they show that 74.6 percent in the under 25 to 99-bed bracket and 48.1 percent of all hospitals are apparently without proper pharmaceutical service.*

What are the responsibilities of the small hospital? First, as I mentioned before, small hospitals have a moral responsibility to their patients to give them the best care known to medical science. This, I believe, is their greatest obligation. We know that they carefully scrutinize all physicians who apply for hospital privileges, and make sure that they have enough capable nurses on the hospital staff. Why not, then, have the same concern for proper pharmacy service, which plays just as great a part in total patient care? Without well-organized pharmacy services, a hospital can scarcely be expected to operate efficiently.

MANY LEGAL RESPONSIBILITIES

Small hospitals have many legal responsibilities, and the practice of pharmacy rates high on the list. The fact that the practice of pharmacy is sometimes carried on in hospitals by persons who are not registered pharmacists has caused some concern. In permitting the filling of prescriptions and dispensing of drugs by insufficiently qualified employees, the hospital administration takes a definite risk for which it is legally responsible.

Obviously, all hospital patients should have the protection afforded by state pharmacy laws. All states require that pharmacists be registered by the state board, either after examination or by reciprocity. If the pharmacist or the person acting in that capacity is not registered, the hospital may find itself at a disadvantage if a claim for damages is made against the hospital and the pharmacist.

Furthermore, laws of most states require that only licensed pharmacists may compound prescriptions. A licensed pharmacist may be on a full or part-time basis, depending on the hospital's requirements, and he alone should be allowed to dispense prescriptions. For example, the Licensure Rules and Regulations for Hospitals and Sanatoria in Massachusetts, Chapter 12, Section A, reads:

"(1) A hospital or sanatorium which maintains a pharmacy for the purpose of compounding and dispensing drugs, shall provide pharmaceutical services under the direction of a pharmacist registered by the Massachusetts Board of Registration in Pharmacy.

"(2) The services of such a registered pharmacist shall be full or part-time, according to the size and demands of the hospital and sanatorium.

"(3) The pharmacy shall be so equipped with facilities, apparatus, utensils, pharmaceuticals, chemicals and drugs as to comply strictly with Rule 18 of the Rules and Regulations established by the Massachusetts Board of Registration in Pharmacy."

Numerous other incidences in which a hospital may be held liable include substitution of drugs, common negligence in filling prescriptions, and mislabeling or misbranding drugs or poisons.

THE ECONOMIC RESPONSIBILITY

Then there is the hospital's economic responsibility. The hospital owes the best possible care to its patients at a cost within the average patient's means. But it costs a great deal more to run a hospital than the average patient can afford to pay. Therefore, the hospital must economize to operate with limited funds.

Before giving my suggestions as to how these responsibilities can be met with the pharmacist's help, let me point out the background, versatility, and education of the pharmacist. He attends a recognized college of pharmacy, graduating after four years with a bachelor of science degree. His training includes 3,200 clock hours of study in both classroom and laboratory. Some of his many courses are: pharmacy, bacteriology, biochemistry, pharmacology, public health, economics, accounting and purchasing.

These qualify him to take over other duties besides operating the pharmacy in a hospital too small to afford a full-time man. He might perform one or more of these duties, depending on the situation:

Laboratory technician
Purchasing and supplies (other than drugs)
General administrative duties
Operation of central supply
X-ray technician (with further training)

Why not engage the services of a local commercial pharmacy to compound and dispense the medications for a small hospital? I deem this expensive and inconvenient, for it denies the patient both service and saving. For example, one small New England hospital is charged 25 percent over the cost of the medication by the drug store. The hospital in turn charges the patient list price plus a 10 percent handling fee. This is at least 25 percent more than the hospital with a pharmacist would pay for the drug, and possibly five or 10 percent more than the patient would be charged.

To summarize:

(1) The small hospital, although limited in size and funds, is obligated to give patients the best medical care—economically, legally and morally.

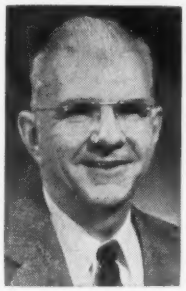
(2) There is a need for concern due to the percentage of hospitals operating without proper pharmacy services.

(3) The qualifications of a pharmacist prove that he is able to save the hospital much added expense by performing other important duties.

Figures are taken from Administrators Guide issue of Hospitals, *June, 1954, and are based on the 84 percent of all hospitals that replied to the survey.*

TRADE TOPICS...

New Division Manager Announced by Edison



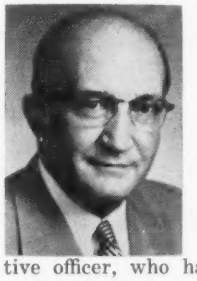
Clyde B. Gardenier has been appointed manager of the Medical Gas Division, Thomas A. Edison, Inc. Mr. Gardenier, who holds a chemical engineering degree from Pratt Institute of Technology, has been with the Edison Co. since 1920.

He is credited with many outstanding developments in the field of gaseous anesthetics, including the Ionoscope for continuous testing of gases; processes for the manufacture of nitrous oxide, cyclopropane and carbon dioxide absorbents, and the Edison Etherizer. Prior to his new appointment, Mr. Gardenier was chief chemist and plant manager.

Walker Joins Bristol Labs

Harlow C. A. Walker has joined the Domestic Sales Division of Bristol Laboratories, Inc., Syracuse, N.Y. He will make his headquarters in New York City. He was formerly assistant sales manager of Schenley Laboratories.

Colgate-Palmolive Ltd. Names New President



C. G. Grace has been appointed president of Colgate-Palmolive Ltd., Toronto, Canada. The appointment coincides with the retirement of C. R. Vint, chief executive officer, who has been associated with Colgate-Palmolive Co. for 51 years. Mr. Vint will remain as a director of the company.

Mr. Grace, who joined Colgate in 1929, has been executive vice president and general manager, and a member of the board of directors of the Canadian company since March, 1954.

"March of Medicine" Receives Award

For their outstanding contribution to public understanding of the problem of mental illness, the American Medical Association and Smith, Kline & French Laboratories were honored recently by the National Association for Mental Health.

The tribute to the March of Medicine telecast entitled "Search for Sanity" was presented by Mrs. Felix duPont, board member of the mental health group, to Leo H. Bartemeier, M.D., chairman, A.M.A. Committee on Mental Health, and Francis Boyer, president, Smith, Kline & French Laboratories.

Occupational Therapy Equipment Firm Formed

Franklin Hospital Equipment Co., an affiliate of the Franklin Machine Co., Newark, N. J., has been organized to design and manufacture tilting tables, arm slings, bicycle jig-saws, parallel bars and other types of physical and occupational therapy equipment for hospitals, and rehabilitation and recreation centers. The company is located at 116 Academy Street, Newark 2, N. J.

Lederle Laboratories Names Sales Manager

Charles K. Piercy has been named domestic sales manager, Lederle Laboratories Division, American Cyanamid Co. Mr. Piercy, former assistant domestic sales manager, replaces T. B. Van Stone, who has resigned for reasons of health.

Lyle Williams Heads New Department

The Food Machinery and Chemical Corp., with headquarters in San Jose, Calif., has announced the appointment of Lyle M. Williams to head its newly established kitchen equipment department. With headquarters in Chicago, Mr. Williams will have general supervision of all phases of the kitchen equipment sales, merchandising, service and advertising program.

Holding the nominal title of district sales manager of the new FMC department, he will have direct responsibility for sales in the entire territory east of the Rocky Mountains, including the Canadian provinces of Manitoba, Ontario, Quebec and New Brunswick. He came to FMC from Magic Chef, Inc.

(Continued on page 76)

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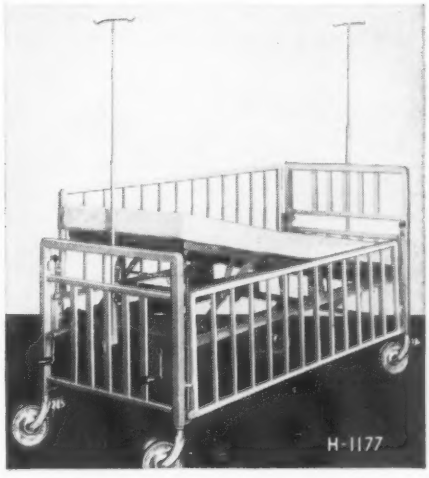

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REVIEW OF HOSPITAL

LAW SUITS

By Leo Parker, Attorney at Law

LEGAL DUTY OF HOSPITALS

During the past several months I received several inquiries from hospital officials who asked substantially this same question: "What legal duty do hospital officials and employees owe patients? What legal rule is available by which hospital officials and employees can determine whether due care has been exercised by a physician employed by a hospital?"

Just recently I located a leading higher court decision which clearly answers these questions. This court held that it is the duty of a private hospital to give a patient such reasonable care and attention as the patient's "known" condition requires.

This court explained that in arriving at a conclusion as to whether a patient was given due care, the degree of care, skill and diligence customarily exercised by hospitals generally in the same community must be considered. In other words, if the hospital employees failed to exercise the same degree of care as would have been used by other employees in hospitals in the same community, the hospital is liable in damages for resultant injuries to a patient.

For example, in *Garfield Memorial Hospital v. Marshall, 204 Fed. (2d) 721,* it was shown that Noel Marshall suffered an injury which produced an intracranial hemorrhage when she was prematurely born in Garfield Memorial Hospital. As a result she is in a spastic condition, 90 percent deficient and incurable. Through her father, George Marshall, she sued the hospital.

The Garfield Memorial Hospital appealed to the higher court and facts were proved, as follows: Dr. Irani is a physician employed by the hospital. He was the "assistant resident" in charge of the obstetrical ward. When Mrs. Marshall was in the seventh month of pregnancy she suffered a rupture of the uterine membranes. At the direction of her private physician she entered the Garfield Memorial Hospital the next day. The ruptured condition of the membranes, which made probable a premature and rapid delivery, was noted on the hospital's record of admission.

Dr. Irani saw Mrs. Marshall daily, sometimes more than once. Mrs. Marshall carefully observed the progress of her labor, timed the frequency and duration of her contractions. Contractions started at 2:00 p.m. and were from five to eight minutes apart. They gradually grew more severe and more regular, until at 5:30 p.m. they were five minutes apart. At that time a nurse called Dr. Irani. He did not come until 7:30 p.m., when the pains were very severe, made a rectal examination (the purpose of which is to determine whether the patient has dilated) and left.

The pains progressed, became harder and closer together until about 9:30 p.m. when they were two minutes apart, and at that time they were lasting from 40 to 70 seconds. At about 9:30, in response to a call from a nurse, Dr. Irani came, felt the contractions, and told Mrs. Marshall she had nothing to worry about. Also, Dr. Irani made this same statement to Mr. Marshall, and to another nurse. At this time seconal and demerol were administered and Mrs. Marshall dozed. About 10:15 p.m. she was awakened by a "terrific pain." Mrs. Marshall shouted for a nurse who telephoned Dr. Irani, who said to "call back later."

Soon afterward the nurse telephoned Dr. Irani who said he could not come. About this time the child's head came down, and had left the uterus. Two nurses took Mrs. Marshall to the delivery room. The cart was placed alongside the delivery table. She had barely gotten onto the table after much struggling when the baby was born. The two nurses were still in the room. One said to the other, "Get a doctor quick; any doctor." One left and returned with Dr. Radford Brown, a private obstetrician who happened to be nearby. A delivery room nurse was severing the umbilical cord when Dr. Brown arrived. He was not scrubbed, but he completed the third stage of labor, which consisted of expelling the placenta. Dr. Irani did not see Mrs. Marshall after his last visit about 9:00 p.m.

In view of this testimony, the higher court approved the lower court's verdict holding the Garfield Memorial Hospital liable for $57,000 damages, and said:

"If the hospital undertakes to render services customarily performed by physicians, it must perform such services with the same degree of care to which a private physician is held; that is to say, the physician employed by the hospital must exercise the ordinary skill and care which is exercised generally by the members of his profession in the community, giving consideration to modern learning."

This higher court also explained that it was the duty of the attending nurse to call an intern when she thought the patient's condition required the services of a physician; that it was the duty of the intern to respond to that call, if possible; that it was the duty of the intern, or in an emergency the nurse, to call the private physician when true labor began. It was the further duty of the hospital, when the process of delivery was obviously imminent or had commenced, to endeavor to furnish an intern or other physician to act until the privately employed doctor could arrive. In this respect, the higher court said:

"The record abounds with instances which sufficiently support the jury's conclusion that the hospital was negligent."

It is important to observe further, that the hospital presented testimony showing that Dr. Irani could not attend to Mrs. Marshall, because at this very time he was delivering triplets from another patient in the hospital. In this respect, the court said:

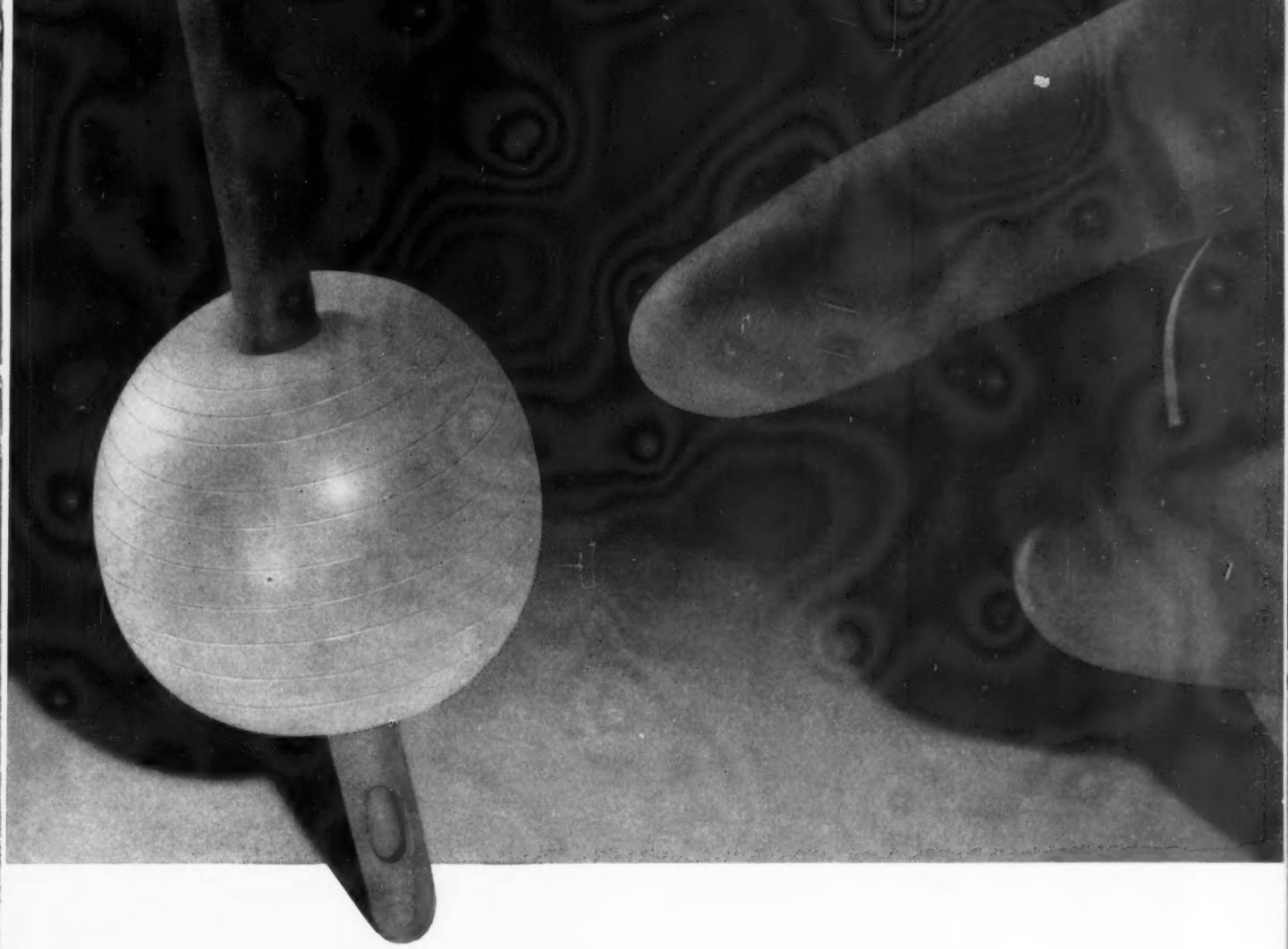
"The fact that Dr. Irani was attending the birth of triplets does not seem to us to excuse or justify leaving Mrs. Marshall without attention."

For comparison, see the late and leading case of *Mastrangelo v. Maverick Dispensary, 115 N. E. (2d) 455.* In this case a patient had considerable suffering and death due to the alleged negligent maintenance of a public charitable hospital. The higher court refused to hold the hospital liable, saying:

"A hospital, which was a public charitable corporation, was not liable in tort action for injuries sustained by patient in the hospital as result of hospital's alleged negligence."

Readers who desire to read similar higher court decisions, see cases as follows: *McDonald v. Massachusetts General Hospital, 120 Mass. 432; Roosen v. Bent Hospital, 126 N. E. 392, 14 A.L.R. 563; Kidd v. Massachusetts Homeopathic Hospital, 130 N. E. 55; and Foley v. Wesson Memorial Hospital, 141 N. E. 113.*

(Continued on page 42)



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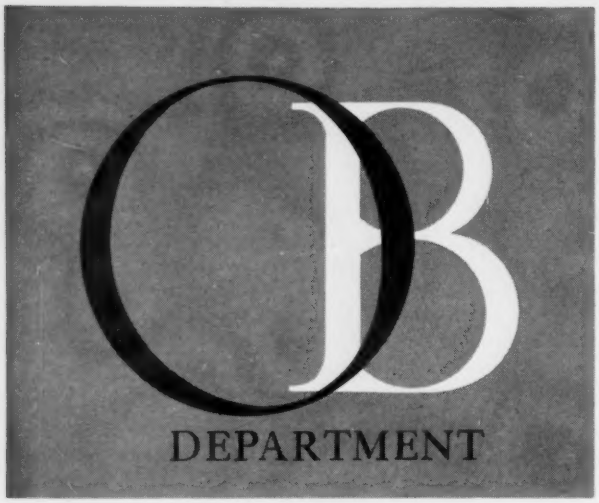


O.B. Conducts "Business as Usual" During Extensive Remodeling

HOLLYWOOD PRESBYTERIAN HOSPITAL, Los Angeles, had a problem: How to remodel its delivery suite and still maintain normal obstetrical services during the construction period.

Its solution, as worked out by administrator Paul C. Elliott, his assistant, Percy F. Riggs, and members of the obstetrical department staff, was to set up two makeshift delivery rooms—one in a large four-bed ward on a bridge between the wing containing the delivery suite and that containing maternity patients' rooms and the nursery, and one in a large single room.

During the six-months' construction period, the emergency set-up enabled the hospital's attending obstetricians to continue to deliver approximately 200 babies a month.

While the $50,000 remodeling program was under way, staff doctors complained about the blueprints. Assistant administrator Riggs called them together one evening in the torn-up suite, showed them the blueprints, and asked for suggestions. Now everybody is pleased with the results.

The first two rooms tried when the emergency set-up was being established proved too small. One of the staff physicians suggested moving to the larger room (the four-bed ward). Staff members found it much easier to maintain a sterile field in that room. On one side of the ward was a flower room, which was set up as a utility room and storeroom; on the other side was a bathroom.

The second delivery room (the large single room) was across the hall, as was the scrub area. Incubators were in the area that separated the two rooms. An old examining room served as the workroom.

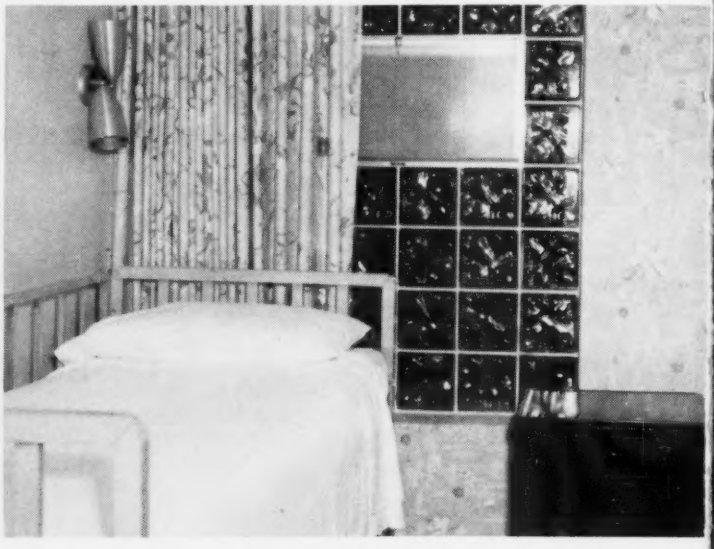
Since the rooms had no overhead lights, portable lights were used.

DISADVANTAGES

Like any temporary set-up, the arrangement had its disadvantages. Rooms were crowded—even the larger one, which was most frequently used—because they were not as large as the permanent delivery rooms. The floors, covered with linoleum, were non-conductive. Labor rooms were farther from the delivery rooms than usual. The temporary workroom lacked the needed cupboard space for storing supplies. Patients' bed linen was kept in cup-

Mrs. Hazel Crowell, aid, gets Piper forceps out of built-in shelves.

Typical labor room. Lighting and colors are subdued, to help patients sleep.



boards in the corridor, near the delivery room doors. Stretchers were usually in the corridor.

ADVANTAGES

One feature which was both an advantage and a disadvantage was the nearness of the temporary rooms to the nursery. The staff didn't like the idea of having the "traffic" to the nursery so near the delivery area; on the other hand, it was convenient to have the nursery nearby following delivery.

In the temporary suite, two rooms were set aside for interns and attending physicians—one in which they could change their clothes and lounge, and one in which they could sleep without being disturbed. There were more patients' rooms which could be used as labor rooms.

Staff physicians and nurses cooperated cheerfully during the construction period, says obstetrical supervisor Gwendolyn Cooper, R. N., but were glad to get into the beautiful new suite, pictures of which are shown on these pages.

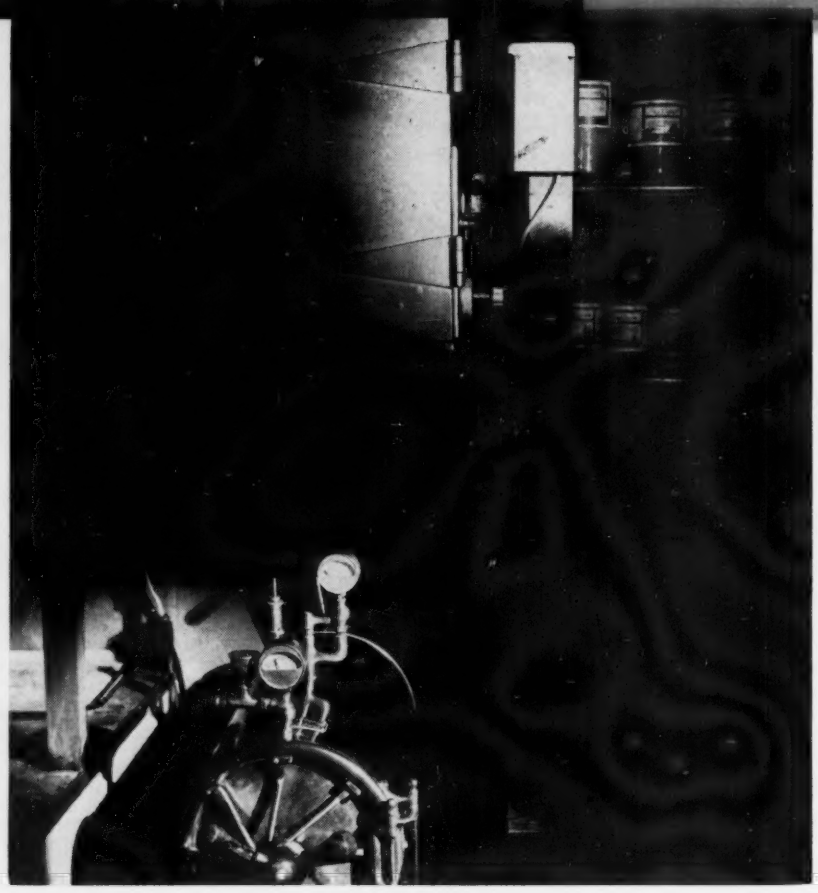
Right: Jo Ann Nisbet, R.N., staff nurse, speaks to new father on intercom which is connected only with fathers' waiting room. A father can answer from a similar speaker in the waiting room. In background of picture (in opening to next area) is nursery intercom.

Below: Patients are admitted directly to delivery suite. Here Gwendolyn Cooper, R.N., B.S., obstetrical supervisor, checks necessary equipment in admitting room. Chart (single sheet) on her clip board is used to trace all of patient's delivery record, and includes an anesthesia chart on one side.

Below: Doctors' scrub area is situated between two delivery rooms, across the hall from the cesarean room. Note "windows" above sinks and on opposite side, so that doctors can watch what's going on in either delivery room while they are scrubbing.

Below: Miss Cooper at headnurse's desk, situated at entrance to utility and clean-up area. Delivery room for cesarean sections is at right.

THE LAB



DEODORIZING LAMP. Westinghouse "Odor-out" bulbs generate ultra violet light which causes production of ozone which neutralizes odors. In this case used near autoclave to reduce odors from sterilization of old media.

● Old equipment can often be modernized by slight alteration. For example, water jacketed gas heated ovens can be easily converted to electrical control. The photograph below shows how this may be done by placing heating element and thermoswitch through original or constructed openings into the water compartment. If the heater is not long enough to extend to the bottom of the oven, the shaft may be cut in two near the top, the wires cut, a section of wire spliced in, and the shaft extended by soldering a copper pipe of appropriate diameter and length.

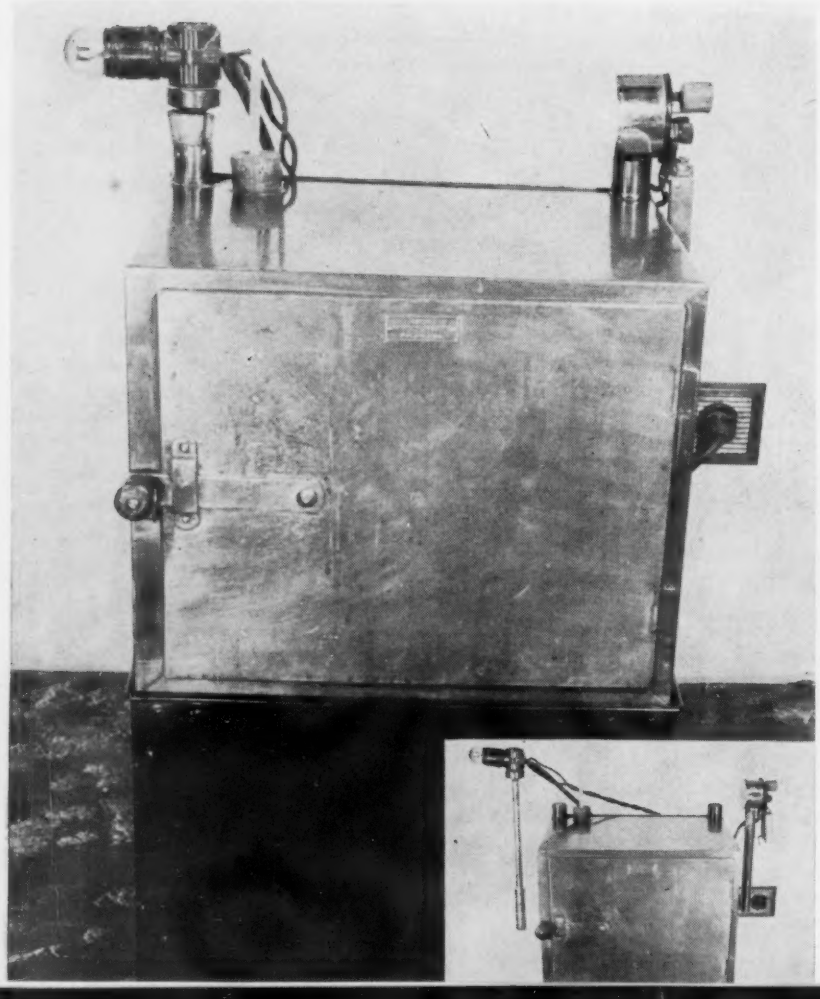
Efficiency in the Laboratory

By E. E. Myers, M.D.
Director of Laboratories
The Myers Clinic
Philippi, W. Va.

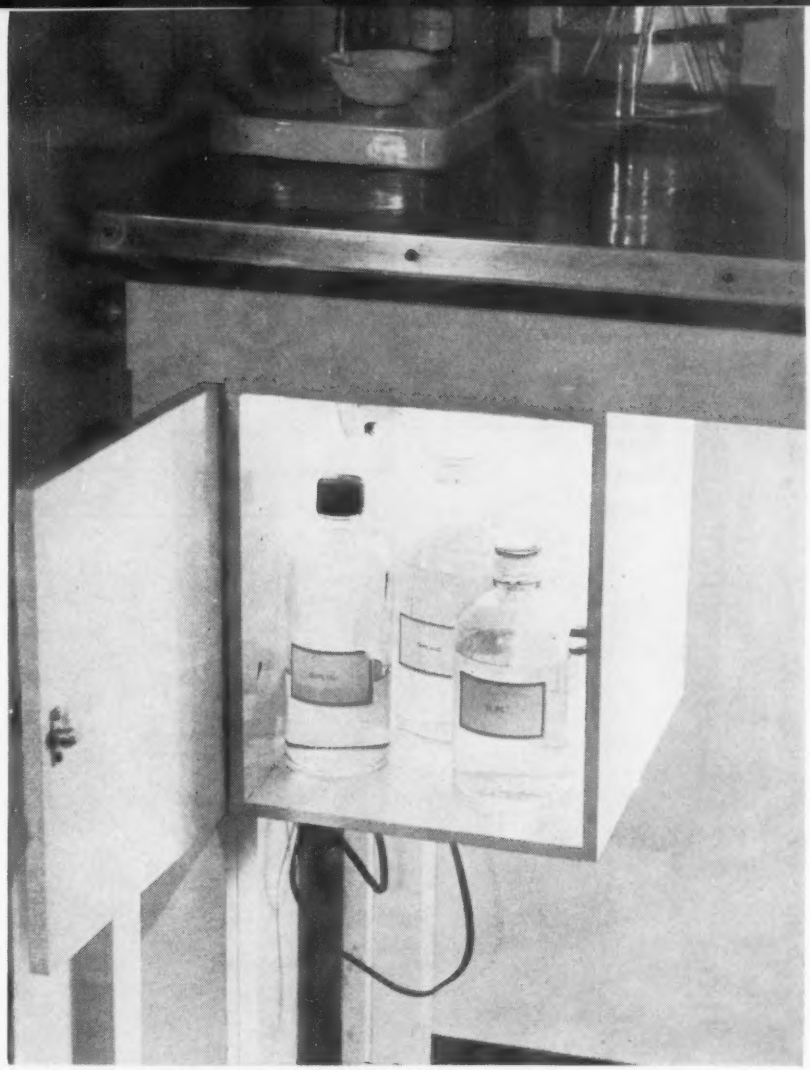
Fifth in a Series

A box with small light bulb can be used to keep solutions at a desired temperature so that time is saved in heating and handling when warm solutions are needed. This applies to solutions for duodenal drainage which are best instilled at, or slightly above, body temperature.

To avoid the annoyance of odors in the laboratory, hoods and exhaust fans can be used. If these do not adequately remove odors or are not feasi-



CONVERSION OF GAS HEATED UNIT TO ELECTRICAL CONTROL. Old style, water jacket, gas heated paraffin oven converted to electrically heated and controlled oven. An extra hole is made into water jacket on left side, similar to original hole on right. Immersion heater, 150 watt, inserted into water jacket on left and thermo-regulator into water jacket on right. Constant temperature to approximately ± ¼° C. Only attention needed is cleaning points once a year with No. 00 sandpaper and tissue paper, and adding distilled water occasionally. Insert shows heater and thermo-regulator.



BOX TO KEEP SOLUTIONS WARM FOR GASTRIC ANALYSIS AND DUODENAL DRAINAGE. A 15 watt bulb keeps solutions at about 37° C.

ble in certain locations, the odors can be "neutralized" by means of deodorizing lamps. These seem to be very effective, especially against certain odors from organic materials. They may be used near the urine table, stool examination table, in the autopsy room, etc. There is, however, some question concerning the toxicity of the ozone produced by these lamps.

Any apparatus which is operated by a storage battery should have a switch box arrangement to throw the storage battery from the equipment to charging. The diagram on the following page shows the wiring connections for such a unit constructed for a flame photometer. The materials for this unit cost about $20.

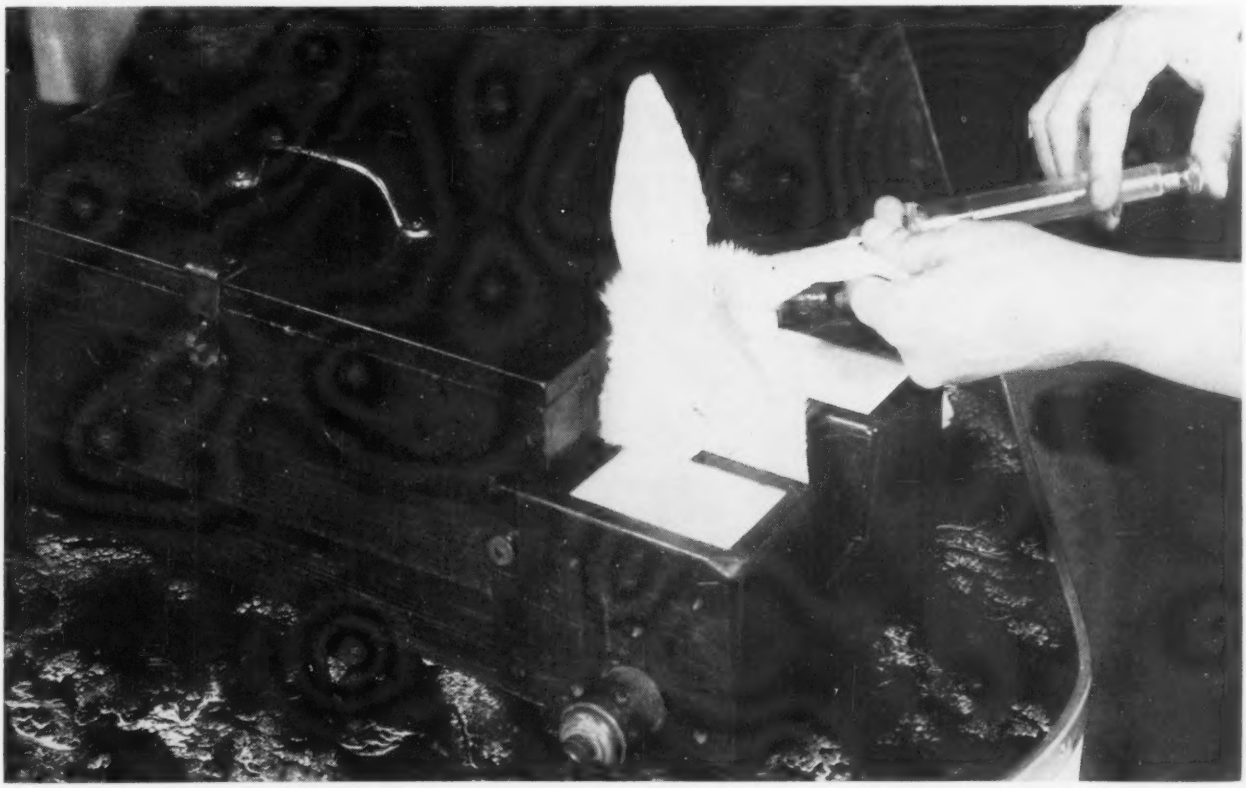
When several specimens are examined at one time, a clip-board to hold the report slips saves time and trouble in recording the results and helps prevent error.

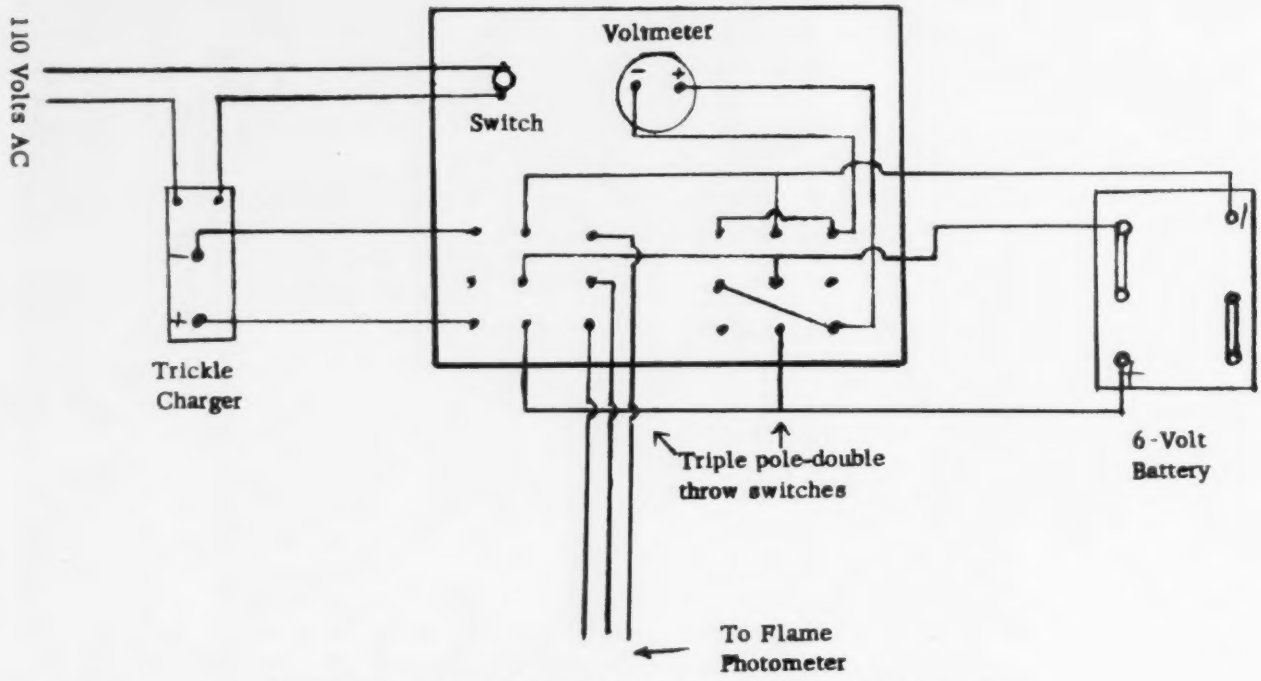
Signs properly located will help patients and visitors locate the laboratory and departments without having to interrupt personnel by asking questions. Desk signs also help.

In doing the Friedman test one per-

(Continued on next page)

AID TO INJECTING THE EAR VEIN OF A RABBIT. A 40 watt tubular bulb beneath opal glass windows gives light which shows up veins.



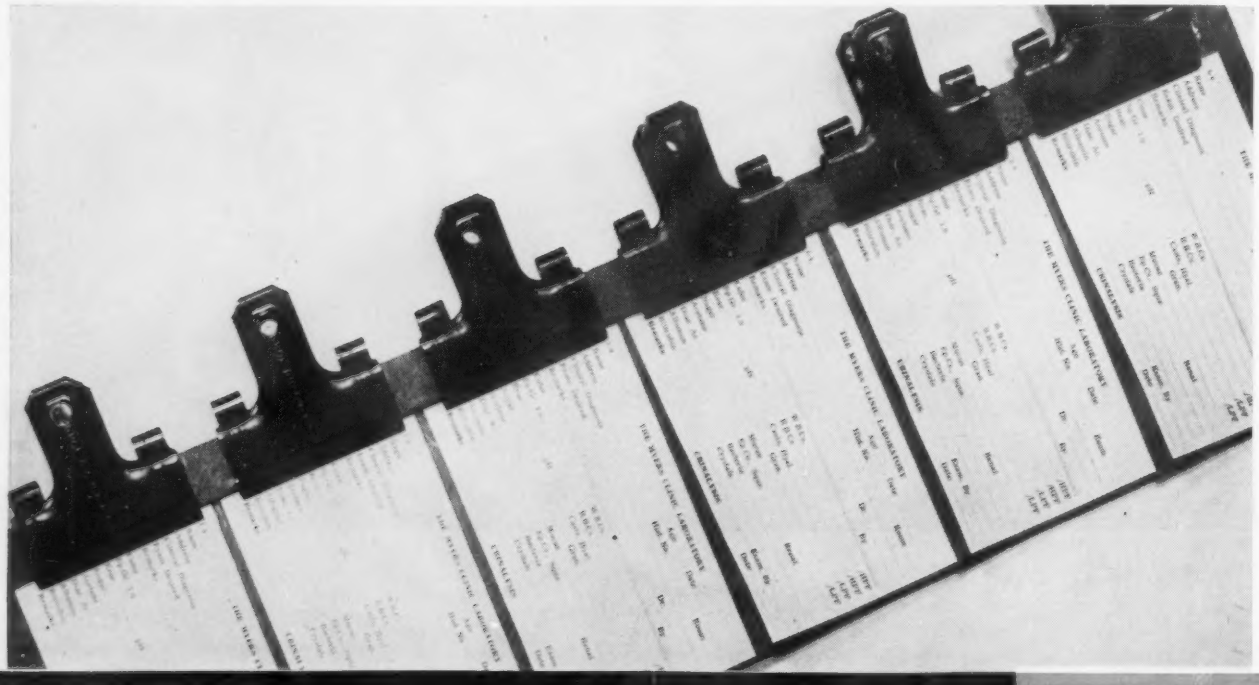


Above: WIRING DIAGRAM FOR SWITCH CONTROL PANEL FOR FLAME PHOTOMETER.

Above: Signs distributed in proper places give directions to patients and others, causing less disturbance to personnel by questions. Below: CLIP BOARD FOR HOLDING URINALYSIS REPORT SLIPS. This is especially useful for holding original with carbon paper and duplicate. The slips shown in the photograph are 3" x 5". Clips are ordinary stationery clips riveted to a masonite board. A strip of masonite glued under the clips makes a stop for the slips.

son may hold the rabbit and inject the ear vein if a box is used for holding the rabbit. A light placed beneath the ear causes the veins to be easily seen and makes it much easier to insert the needle into the vein.

Every piece of apparatus should be studied as regards its location and its function, and also each step in doing a test should be studied for possible improvement. Only by a systematic approach, with endeavor to save time, effort and prevent error, will maximum efficiency be effected.



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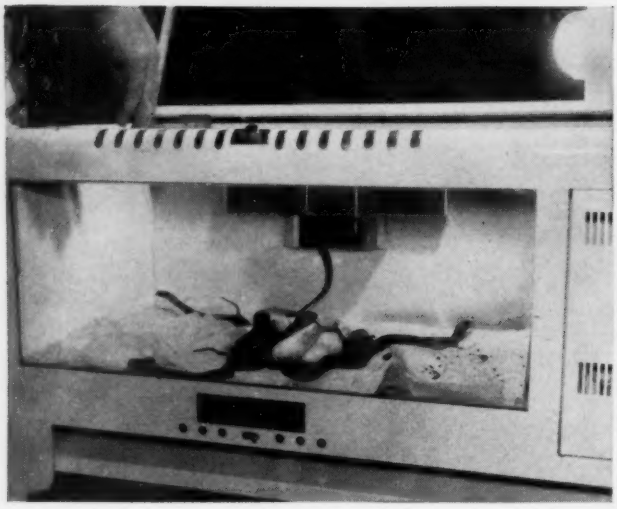

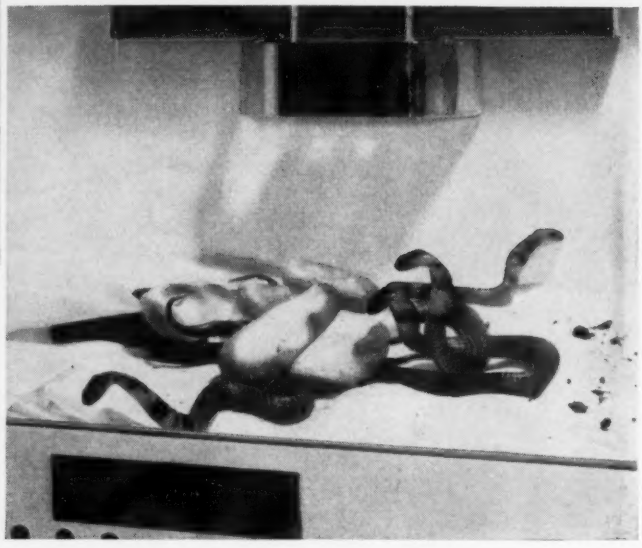

how come?

...Indian Cobras in an Armstrong X-4 Baby Incubator?

Because there's an exceptionally interesting, unusual story back of this photograph, we've borrowed a page from television's book and are making a guessing game out of the answer to "How Come?" To the first physician, hospital official, or nurse regularly connected with a hospital, who sends us the correct answer to "How Come—Indian Cobras in an Armstrong X-4 Baby Incubator?" we will pay a $50.00 cash award. In addition, we will ship—free, express prepaid, one complete Armstrong X-4 Baby Incubator to any hospital chosen by the winner.

(Incidentally, don't jump off the deep end and tear us apart about snakes in an Armstrong X-4 Baby Incubator—wait until you hear the story).

There are only a few rules to follow:

1. The contest is open to any physician or any member of a hospital staff (administrators, nurses or technicians) in the United States or Canada.

2. The writer of the FIRST most nearly correct answer of not over 50 words will be awarded personally $50.00 in cash. Also one complete, latest model, Armstrong X-4 (Nursery Type) Baby Incubator, with all transportation charges prepaid will be shipped FREE to any hospital designated.

3. Address your 50 word letter (and please print your name and the name of the Hospital) to:

Indian Cobras
c/o The Gordon Armstrong Company, Inc.
504 Bulkley Building, Cleveland 15, Ohio

4. Each envelope marked "Indian Cobras" will be stamped with a number as soon as it is received. When opened, the letter will be stamped with the same number. (Please, no telegrams or phone calls).

5. The contest closes March 1, 1955. Postmarks on envelopes will establish the date. All entries will be acknowledged.

6. The decision of The Gordon Armstrong Company, Inc. is final. All letters become our property. The name of the winner will be announced in this magazine—the May issue if possible.

We hope you will accept this contest in the same spirit that prompts the idea and send us your answer as soon as possible. Remember—it's the FIRST correct answer that counts.

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Pediatric Nursing

Philosophy of the "Whole Child" Stressed at Children's Memorial

By Esther L. Voorsanger, R.N., M.A.
Assistant Director, School of Pediatric Nursing
The Children's Memorial Hospital, Chicago

Making friends during bedside care.

• Parents of small patients find, when their children are admitted to Chicago's Children's Memorial Hospital, that not only are the beds, clothing and physical facilities especially tailored to child size, but also the attitudes, approaches and philosophies of nurses, doctors and all who work with the children. Since 1925 Children's Memorial has had an affiliated school of pediatric nursing. At present 15 hospitals send nearly 450 young women and several men each year for basic experience in the nursing of children. These professional student nurses are given a three-month program of theory and concurrent clinical experience.

When these young people arrive at the hospital they come with varying backgrounds, experiences and preconceived ideas about children and their care. It is our job to help them understand the "hows and whys" of child care. We feel that this is a background fundamental not only to effective nursing care for the child, but that it also aids them in giving better care to adult patients. It also serves as a training ground for the student nurse as a prospective parent.

The philosophy of the care of the "whole child" is emphasized and carried out at Children's Memorial. The need for security, for love, for "T.L.C." is pointed up at all times. The importance of emotional and social well being to the child's recovery, as well as the most careful physical care, is constantly emphasized, for the

(Continued on next page)

At left: Classroom instruction by medical staff.

Nurse and parent share concern for child entering hospital.

PEDIATRIC NURSING continued

insecure child recovers slowly. Necessary modifications of procedures and technics already familiar, and special procedures peculiar to child care, are presented to the student.

All available areas in the hospital are used in teaching nursing care of children to the students. Formal classes during the first six weeks of their affiliation find members of the medical and nursing staffs giving help in understanding the needs of children. Specialists in the fields of growth and development, endoscopy, cardiac surgery, infant feeding, child guidance and many other areas present their material.

Nursing care classes and clinical teaching are correlated with the medical lectures. Movies, slides and other audio-visual aids are used liberally to emphasize important points and to make the classes more interesting.

Clinical practice is given in caring for infants and older children in the acute and chronic stages, as well as in the outpatient department and occupational therapy unit. Field trips to nursery schools and correlation studies of sick and well children assist the students in pin pointing the importance of knowledge and understanding of the normal child, and the effect of these upon his behavior when ill.

It is the hope of the faculty of the school of pediatric nursing that at the completion of their three-month affiliation, the student nurses will have gained the following:

(1) A thorough knowledge of the scientific principles involved in the technic and skills required in caring for children in illness and in health.

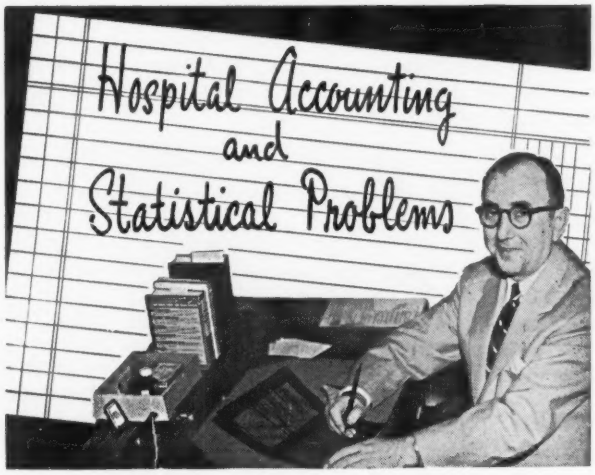
(2) An understanding and appreciation of the philosophy of the care of the "whole child," recognizing his place as a member of a family and of the community.

(3) Enrichment and stimulation of the students themselves, in an effort to make them professionally and civically more desirable citizens with healthy social habits and attitudes.

Having gained all the above, it is hoped that student nurses will be better able to create an atmosphere in which the miracles of recovery can take place.

A child's play is a child's work.

Clinical experience is supervised by instructor.



By David H. Tarlow, C.P.A.

Q. We have just completed a building program and find that various notes payable were issued to sub-contractors and equipment firms. I am setting up the books of account and would appreciate any assistance you can give me as to what routine I should follow to ascertain the correct status of the hospital's liability.

A. I would suggest that you obtain a copy of the bulletin issued by the American Institute of Accountants, called *Examination of Financial Statements*, which covers this subject thoroughly. In the meantime I would suggest that you ask the board of trustees to assist you in preparing the following schedule with respect to all notes issued:

(1) Payee
(2) Date issued
(3) Due date
(4) Amount payable and for what purpose
(5) Interest rate
(6) Collateral, if any
(7) Endorsers, if any
(8) Interest accrued to date of recording items on your books of account
(9) Confirmation of notes payable directly with banks or payees before making formal entry

* * *

Q. We have a number of shares of common stock which were given to the hospital during the fund raising campaign. The majority of these securities represent firms not listed on the various stock exchanges and are traded over-the-counter. How would you arrive at a valuation for balance sheet purposes?

A. In some instances we find that boards of trustees recommend that such items be carried on the books of account at a nominal value of $1.00. If, however, you are desirous of obtaining a market value, you could refer to the Wall Street Journal which lists such securities, or have your bank or broker obtain such information for you. If you do set the items up on the books of account at a market value, we would suggest that you make a thorough examination in the general journal as to the authority for such valuation.

* * *

Q. Can trade discounts be computed by other means than using the step down method in the determination of the amount due to the creditor? We sometimes have three computations on the same invoice.

A. Assuming the list price of the item in question is $1,000 and the trade discounts used are 30-20-10, the actual price is computed as follows:

List price	$1,000
Less 30%	300
	700
Less 20%	140
	560
Less 10%	56
Your price	$504

This series of trade discounts may be reduced to a single computation in the following manner:

100%	100%	100%
−30%	−20%	−10%
70%	80%	90%

70% x 80% x 90% = 50.4%
100% −50.4% = 49.6%

Therefore a single discount of 49.6% will produce the same price as the 30-20-10 series.

* * *

Q. Is there a simpler way of recording cash receipts in the cash journal than by listing each individual payer for accounts receivable credits? Or is it mandatory to list each name?

A. I assume that you issue a receipt from a chronologically numbered receipt book to all patients or individuals paying hospital bills. It is suggested that you make one entry per day for receipts from such sources by listing the receipt numbers covered in the folio or name column of the cash receipts journal.

* * *

Q. We are considering the establishment of a depreciation policy for all fixed assets at our hospital. Can you give us suggestions as to the methods used by other hospitals in doing this?

A. We realize that there are many opinions as to the so-called best method for hospitals to compute depreciation. All have their good and bad features. You can make your choice from the following as to the best method for your particular institution.

(1) Straight line method
(2) Declining balance method
(3) Sinking fund method
(4) Replacement method
(5) Appraisal method

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(Continued from page 30)

MUST PROTECT PATIENTS

Irrespective of ordinary facts, patients and circumstances, hospital employees are legally obligated at all times to protect a patient known to be incompetent to safeguard himself against injury. Quite obviously, there is a fine line of distinction between a patient who is and who is not competent to protect himself. Generally speaking, the jury will decide this question.

For example, in *Houston v. Tri-State, 37 S. E. (2d) 64,* the testimony showed that a man named Houston was drinking whiskey but was not boisterous or disorderly. However, a witness testified that he was mumbling and seemed to be intoxicated. Soon afterward, Houston was allowed by the corporation's employees to wander on the highway and he was killed by an automobile.

In subsequent litigation, the higher court held the corporation liable in damages to Houston's dependents because the corporation's employees failed to protect Houston against his own folly. The court said:

"It is fairly inferable from the fact and circumstances shown by the evidence that his condition was known to Strickland (corporation's employee). When it was apparent that he was in a drunken or mental state of irresponsibility, then it was Strickland's legal duty to protect him from the consequence of his own folly."

Also, see *10 Am. Jr., sec. 1277, p. 186* as to the duty owed by a hospital to an intoxicated patient. A hospital is under no obligation to accept as a patient one who is intoxicated to such an extent as to incapacitate him from caring for his own safety, but when it does accept such a person as a patient its employees are bound to exercise all the care that a reasonably prudent man would to protect such a person from the dangers incident to his surroundings and mode of travel. In other words, the hospital must bestow upon such patient care and attention beyond that given to the ordinary patient.

STREET IS VALID PARKING LOT

It is well known that ordinarily the owner of real property owns the land to the center of the abutting street. A late higher court held that the owner of real property, as a hospital, can utilize land abutting the street for a parking lot.

For example, in *Embry, Inc. v. Webster, 261 S. W. (2d) 682,* it was shown that the use of real estate in a certain area is restricted to family residences or apartment houses. The avenue is 50 feet wide with a 16-foot center section which is paved, leaving a 17-foot strip on each side of the pavement.

A corporation converted into a parking space the 17-foot strip adjacent to its lot. This parking space was for use and benefit of its patients, patrons and visitors.

Suit was filed by adjacent property owners to enjoin use of this land for automobile parking purposes. These property owners contended that use of this 17-foot strip for parking purposes is a nuisance because the patients, patrons and visitors make noises by slamming doors of their automobiles, racing motors and talking loudly.

It is interesting to observe that the higher court held that the restrictive residential clause will not prevent use, for automobile parking purposes, of the unpaved portion of the street abutting this real estate. The court said:

"The use of the strip, so close to the homes of the complaining property owners, may be annoying to them, but it is no invasion of any of their property interests any more than it is an actionable injury to their persons."

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With either matched or interchangeable barrels and plungers, *Eisele* syringes are precision built to prevent leakage and flow-back. Heat hardened ***five times*** for longer wear and less breakage.

Luer Lock, Metal or Glass tips are the same price.

Typical syringe prices:

2cc matched syringe with repair exchange . . . . . **$11.76** per dozen
2cc matched syringe without repair exchange . . . . . **$13.07** per dozen

10% discount on orders of three gross or more.

Eisele Hypodermic Needles

Hand-honed, side beveled under a magnifying glass for less tissue trauma, Eisele needles are individually inspected for temper, fit and sharpness. A full range of sizes and materials.

Typical needle prices:

25 gauge 5/8 inch rustless needles complete with tube protectors . . . . . **$11.51** per gross

The Eisele policy of selling direct means better syringes and needles at lower cost.

Complete satisfaction guaranteed—*Order the syringes and needles you need from*

EISELE and COMPANY
400 1st Ave., North . . . Nashville, Tennessee

AEROPLAST®

Brand of Vibesate

LIQUID SURGICAL DRESSING

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

is now accepted by the Council on Pharmacy and Chemistry of the American Medical Association

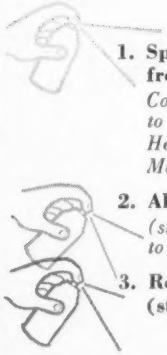
from the N. N. R. Monograph

"VIBESATE — (Aeroplast)

Vibesate is a modified polyvinyl plastic that forms a rapidly drying, transparent, pliable, and occlusive film when applied topically as a liquid spray containing a suitable volatile solvent and gaseous propellant.

Vibesate is useful as an occlusive surgical dressing for burns as well as for operative wounds and other surface lesions, particularly when use of gauze or other fabricated dressings is undesirable or inconvenient. The film also is suitable for covering certain skin eruptions, including macerated excoriations, decubitus and traumatic ulcers, and abrasions."

easy to apply



1. **Spray a light film onto aseptic dry wound from a distance of 6 to 12 inches.**
   Cover adjacent area of intact skin to provide anchorage.
   Hemostasis should be complete.
   May be applied over sutures.
2. **Allow film to dry for 30 seconds.**
   (sufficient time for the acetone solvent to evaporate)
3. **Repeat "spray and let dry" procedure (steps 1 and 2 above) two more times.**

Aeroplast is sterile

Supplied in 6 oz. aerosol-type dispenser.
Available through your surgical dealer.

For literature and reprints write.

AEROPLAST CORPORATION • 419 Dellrose Avenue, Dayton 3, Ohio

These Nurses Help Plan and Reorganize Hospitals

By Margaret K. Schafer, Nurse Consultant
Division of Hospital Facilities
Department of Health, Education, and Welfare
Public Health Service
Washington, D. C.

How can the nurses in the Division of Hospital Facilities, U.S. Public Health Service, help your hospital? They participate in the Hospital Survey and Construction Program by implementing and practicing the philosophy that nursing plays an integral part in planning functional hospitals and related facilities.

The nurses' responsibilities cover a wide range of subjects pertinent to safe, effective patient care in hospitals and related institutions. They work as an integral part of a staff of specialists experienced in hospital planning, construction, and operation. The staff includes physicians, nurses, pharmacists, economists, dietitians, administrators, equipment specialists, architects, and engineers.

Specifically, the nurses' efforts are directed toward providing information and guidance based on sound principles and present-day methods of medical and nursing practices in hospitals, nursing homes, and health centers of different size, type and location. This information assists the architect in planning hospitals which are functional, realistic, attractive, and economical.

Some of the nurses' contributions are applicable to existing hospitals as well as new facilities. Assistance in developing standards for good patient care is given to state agencies administering hospital and nursing home licensing programs.

Consultative services include the division staff and other divisions of the U.S. Public Health Service, Federal governmental agencies, states, individual institutions, national organizations, and individuals of foreign countries.

The nurses conduct studies and prepare guide materials for publication on subjects pertinent to planning and operation of hospitals and related facilities. These materials include such subjects as the patient care units of general and special hospitals, the operating room, recovery room, central supply room, nurses' residence and educational unit, hospital and nursing home licensure programs, and hospital standardization.

The nurses participate in professional meetings by presenting papers, or appearing as institute faculty members with the Hospital Facilities staff, other Federal agencies, state health departments, and hospital and nursing organizations. Subjects of these speeches include nursing service administration, planning hospital facilities and services for a nursing unit, surgery recovery room, central sterile supply room, outpatient department, and hospital licensure.

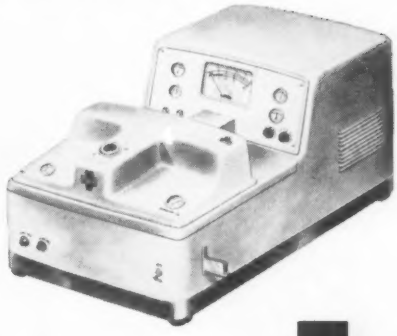
The utilization of nurses in the Division of Hospital Facilities has served as a model for other national, state, and local authorities in the health field in this country and abroad.

Cecilia M. Knox (l.) and Miss Schafer, both nurses consultants in the Division of Hospital Facilities.

EXCLUSIVE ELECTRONIC SHARPOMETER...

Guarantees A·S·R BLADES

THE SHARPEST EVER MADE!



The NEW EXCLUSIVE A. S. R. SHARPOMETER... **the only device of its kind in the world...** measures the CRITICAL EDGE-FINENESS of every lot of

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EDGE-FINENESS determines perfect cutting qualities. Sharpometer Edge-Fineness tests enable A. S. R. to ***guarantee*** . . . precise, uniform sharpness and dependability for every single blade!

NEVER AGAIN will the surgeon suffer embarrassment due to dull blades. A.S.R. SURGICAL BLADES . . . Sharpometer tested . . . *are your safe-guards.*

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PROVED SHARPNESS: Sharpometer tests on competitive blades including re-sharpened ones, have proven . . . beyond a doubt . . . A.S.R. SURGICAL BLADES are uniformly sharper.

NO WIPING REQUIRED — blades are wrapped in rust inhibiting paper.

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Jacuzzi WHIRLPOOL BATH

MODEL J-300 — PATENT PENDING

Doubles usage... halves the cost

Adaptable. Place in tank wherever needed for most beneficial effect. No clamps or bolting necessary.

Versatile and economical . . . one unit serves all therapy tanks or bathtubs.

Effective: Its ⅓ h.p. motor puts out forty-five gallons of churning, aerated water per minute! Force and direction of flow quickly, easily adjustable to patients' specific needs. No maintenance or extra plumbing required. Compact. Weighs only 25 lbs.

Proven: Developed and tested through seven years of research under supervision of physicians.

Safe: Accepted and fully approved for professional use by Underwriters Laboratories. No exposed electrical switches.

Model J-300
Patent
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Jacuzzi WHIRLPOOL BATH

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The Book Corner

Financing Hospital Care in the United States

Volume 1: Factors Affecting the Costs of Hospital Care

Edited by John H. Hayes. Published by The Blakiston Co., Inc., New York and Toronto. 300 pages. In this series three volumes are being published by the Commission on Financing of Hospital Care. This first volume is largely concerned with the scope of the hospital program today and the changing scene as it applies to the cost of running a hospital.

It is the first step in an attempt to provide the maximum in hospital service, reducing the cost only where such reduction will not interfere with the quality of service. And now we find that quality alone will not suffice: the demands of increased population and an increased standard of living require that quality service be supplied in quantity. This is the goal which must be met, and this is what the commission is attempting to provide.

Many tips which may apply to your own hospital can be found in this book. There are improved methods which apply to costs in practically every department. Coordination of services within the hospital, and with other hospitals, often accomplishes much in avoiding duplication of efforts.

Adequate accounting systems and systematic budgeting are as essential to the hospital, as they are to business. This can be done without losing the warmth which identifies the hospital.

The book ends with a well-tabulated summary and a list of 19 recommendations, briefly stated. The meat is contained in these two short chapters, but those who are interested in the administration of the hospital will find many a valuable paragraph or table on practically any page of the book.

American Nursing: History and Interpretation

By Mary M. Roberts, R.N. Published by The Macmillan Co., New York. 688 pages; illustrated. The growth and development of American nursing constitute the growth and development of the entire nursing profession. There is no question but that this country led the world in changing nursing from a menial job to a true profession.

Miss Roberts has spent most of her life watching and contributing to the

(Continued on page 80)

you can produce
prompt, prolonged
surface anesthesia
with one application of

NUPERCAINAL®

Contains Nupercaine® (dibucaine CIBA), one of the most potent and long-acting anesthetics.

Effective in low concentration —sensitization rare (nonnarcotic —not related to cocaine or procaine).

Useful whenever surface anesthesia is required—burns, surgical dressings, hemorrhoids, abrasions, etc.

Ointment (dibucaine ointment CIBA), 1% Nupercaine in lanolin and petrolatum base.

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Ophthalmic Ointment, 0.5% Nupercaine in white petrolatum, applicator-tip tubes.

2/20918

BUYER'S GUIDE

201. Micro-projector easy to operate

The SpeedMatic Micro-Projector developed by Bausch & Lomb Optical Co., operates as simply as an ordinary slide projector. Fast, simple projection of true-color microscope specimens permits group study by doctors, students and laboratory technicians. There are no parts to move about or adjust to obtain a bright, constant, well-focused image on the screen. It is shown above as it would be used to project microscope specimens.

202. New Radarange electronic oven

The new Radarange electronic oven, capable of cooking an 18-lb. roast of beef medium rare in 40 minutes, was demonstrated recently by Raytheon Manufacturing Co. in New York City. Specifically designed for commercial use, the oven's tremendous speed helps reduce food wastage. In the Radarange oven, high frequency radio energy, known as microwaves, penetrates the food to a depth of about two and one-half inches. As it penetrates, it sets up molecular friction deep within the food, which in turn creates heat. This eliminates the need for time-consuming conduction. Since interior of the oven never gets hot, food spillings and spatterings are not "baked on" as in conventional ovens. The chef may reach in with his bare hands and remove platters and pans.

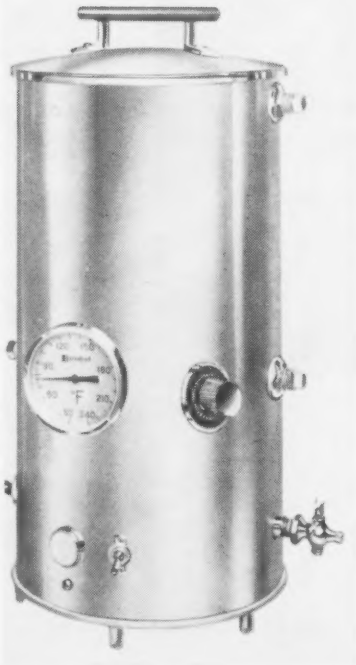
203. Durable floor patch

Quickly mixed and easily applied Trowel-In resurfacing material can be used for patching practically any type of floor—concrete, stone, brick or wood. It requires no chopping of the old floor, and trowels to a true feather-edge. Applied only to ⅜ of an inch, it does not raise floor levels appreciably. Easily trowelled in around machine bases, pipes and other obstructions. Requires no special skill in application or any extra materials such as sand, cement or stone. Repaired floors are ready for traffic in 18 hours. Flexrock Co.

204. Plastisol coated tote basket

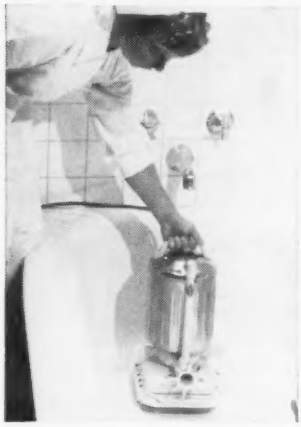
A new utility basket, designed to protect the glaze on china, has a coating of double heat-treated plastisol which acts as a cushion between the chinaware and the metal basket. Coating completely surrounds the wire frame. Wood runners on the bottom protect the plastisol coating against excessive abrasion. Metal runners are optional equipment at no extra cost. Used for bussing dishes and general carrying. Metropolitan Wire Goods Corp.

205. Hot distilled water on tap for instant use



The new Barnstead distilled water heater for laboratories keeps hot distilled water on tap for instant use. Water is maintained automatically at any predetermined temperature by means of an adjustable thermostat. Tank is constructed of tinned copper and has removable cover. Exterior finish is satin nickel plate. Heater has 1½ gallon capacity. A pilot light shows when current is on. Dial type thermometer marked for 30 to 240 F. Supplied with cord and switch. Heating unit, 650 watts. Available for 110 or 220 volts. Barnstead Still & Sterilizer Co.

206. New portable whirlpool unit

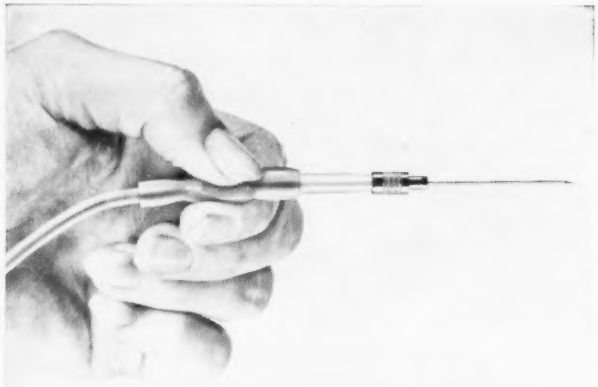


A new device now makes it possible to convert any bathtub or therapy tank into a whirlpool bath whenever needed. Twenty-five pound, completely portable unit puts out 45 gallons of rapidly whirling aerated water per minute. Does not have to be clamped to tank rim, but can be placed wherever desired within bathtub, hip or Hubbard tank to give the most effective treatment. Controls especially designed to enable handicapped patient to regulate direction and force of flow. Approved by Underwriters' Laboratories for professional use. Jacuzzi Bros. Inc.

207. Speedy, versatile adding machine

A new ten-key electric adding machine, particularly adaptable to figuring and accounting work in hospitals and similar institutions, has been announced by Clary Multiplier Corp. Designed with a rotary mechanism, the unit is said to operate as much as 10 percent faster than competitive machines. Mathematical automation makes division and multiplication virtually as practical as adding and subtracting. Other features include clear-channel or "open" keyboard; high-speed multiplication; direct totals without waste cycles beforehand or need for raising hand from keyboard; and totaling that automatically clears out figures indexed in keyboard without use of clear key. Weight, 20 lbs. Supplied in two-tone eye-ease greens and gray.

208. New flashball checks "flashback"

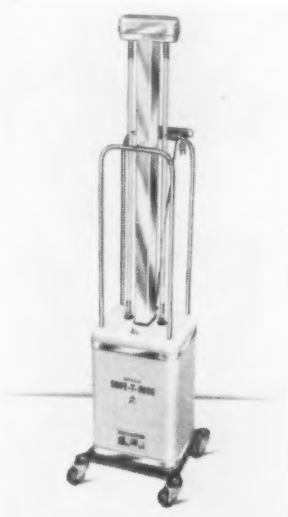


Just squeeze the new flashball on Baxter Plexitron administration sets . . . then release it. When blood flashes back into the needle adapter you know you're in the vein. Designed to save time and trouble in determining position of the vein needle for an intravenous infusion, the flashball also offers another important advantage. When supplemental medication must be added during an infusion, it is no longer necessary to "thread" a syringe needle into a small diameter rubber tubing. The adequate size of the flashball and its special shoulder make needle insertion easy. The flashball will become a standard feature of most expendable blood, plasma and solution administration sets in the Baxter "Plexitron" line, according to a company announcement. Baxter Laboratories, Inc.

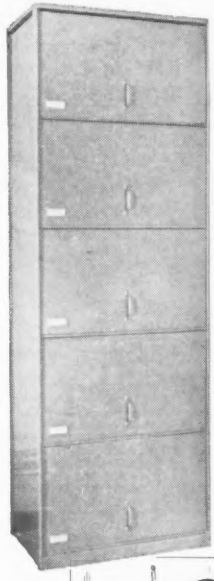
210. Clears clogged plumbing

Easy to operate Handee Ram Rod does a quick job of clearing clogged plumbing with professional efficiency. Useful for unclogging sinks, floor drains, bathtubs, urinals and toilets, it is designed to reach around an unlimited number of 90-degree bends and for getting at furthest trouble-spot. Operates by merely inserting the patented cutter head and reaming coil into drain and turning crank handle. Reams out every bit of obstruction, leaving trap and drain clean. Made of high grade, long wearing metals. Reaming coil consists of 15 feet of ¼" diameter treated Swedish steel. Shor-Line Sewer Equipment Co.

211. Portable room air sterilizer



The Hanovia portable room air sterilizer is a high-intensity ultraviolet irradiator and generating plant. Its rapid destruction of micro-organisms in contaminated areas permits prompt re-use of premises. One hour operation of unit usually suffices for room 30 x 40 ft. Applications include vacated patients' rooms; routine clean-up of operating rooms, autopsy rooms and ambulances, after delivery of infectious cases. Hanovia Chemical & Mfg. Co.



TWICE AS MANY NEGATIVES IN THE SAME SPACE

Visi-Shelf FILING SYSTEM

for

X-RAY NEGATIVES

Files x-ray negatives—

. . . in ½ the space

. . . in ½ the time

. . . at ½ the expense!

The lightweight drop-door opens quickly and easily revealing all negatives in the compartment.

The patented Facile Guide-Pull "locates" the desired negative providing faster filing service.

Write for Complete Details of this New Negative Filing System!

VISI-SHELF FILE INC.

105 READE STREET • NEW YORK 13, N. Y.

BUYER'S GUIDE

Continued

212. Non-woven cotton dust cloth

Wip-eez, a new non-woven cheesecloth for dusting and polishing, is durable, inexpensive and disposable. Perfected after five years of research, this all-cotton product is said to be lintless, triple-absorbent, and priced far below conventional cloth wipers. Super soft—safe for the finest furniture or silver—large square-yard size makes it efficient for wiping and polishing large areas as well as small pieces. Leshner Corp.

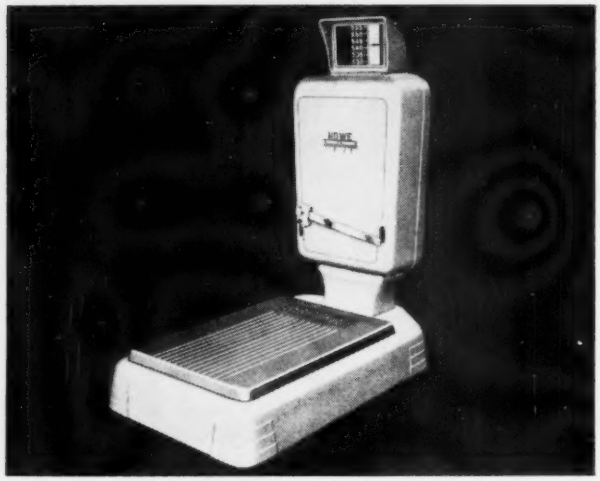
213. New filing system saves space

Verti-File, a practical new system for filing active records, claims a 90 percent increase in capacity over conventional files by using vertical shelving with adjustable snap-in metal dividers on every shelf. Expense per filing inch is said to be 67 percent less than conventional filing equipment costs. Complete visibility and the elimination of file drawers to tug out and push in makes for faster record storage. Available in standard three-foot wide cabinet sections, complete with finished end panels and top. DeLuxe Metal Furniture Co.

214. Removes grease stains from walls

Unsightly grease or oil stains on wallpaper, paint and other hard surfaces can be removed with a new aerosol product supplied in a pressurized container. To apply, spray a generous coating on and around the grease spot, allow it to dry until the film turns white, and then wipe off with a soft clean cloth. Stubborn stains may require two applications. Effective on such materials as lubricating oil, hair oil and cottonseed oil. E. I. Du Pont De Nemours & Co.

215. Self-contained weightograph



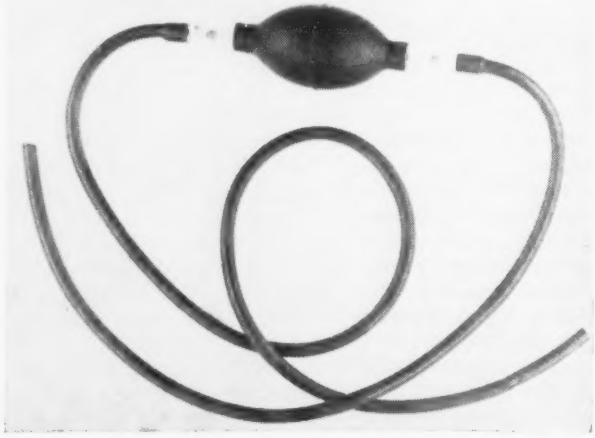
A new streamlined automatic weighing unit announced by The Howe Scale Co., features projection type weight indication. Exact weight, flashed on a large, crystal-clear wide angle "teleview" screen, permits instant, accurate weighing at a glance. Unit incorporates the use of a precision chart on microfilm. Figures and graduations are magnified 28 times their original size, and are reflected on the teleview screen. Light source is an especially long-life prefocused lamp which greatly intensifies the light on the chart. Other features include positive drive, with no lost motion or backlash; agate bearings and knife edge pivots; and easy calibration. Available in short bench or tall column floor styles.

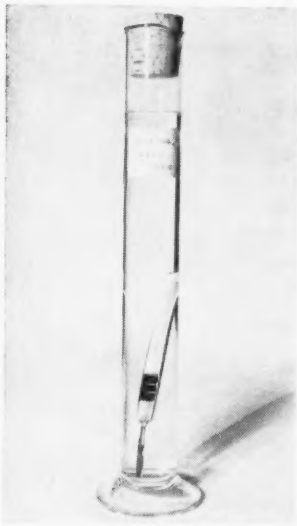
216. Bronze, aluminum, steel metal work

Aluminum and bronze tablets, signs, door plates, letters and numerals. Aluminum, bronze, and stainless steel doors and entrances. Aluminum, bronze, and stainless steel railings and grilles. Newman Brothers, Inc.

217. Self starting rubber syphon and hand pump

This five-foot unit has many uses around laboratories and hospitals. Bulb and tubing are of synthetic rubber and the valves are of plastic. It is unaffected by most inorganic solutions, mineral and animal oils, and low concentrations of alcohol, paraffinic and clefinic hydrocarbons, amines, alkyl monohalides and esters containing more than ten carbon atoms. Pump action starts syphon and easily pumps or syphons liquid from one container to another without spilling. General Scientific Equipment Co.





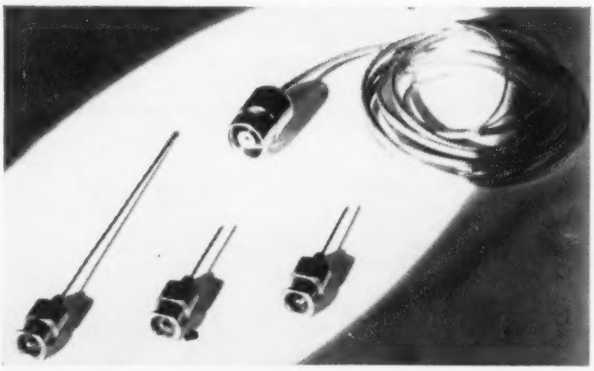
218. Rust and corrosion inhibitor

A new rust and corrosion inhibitor prevents corrosion of metal instruments kept in liquid germicides and disinfectants which are usually highly corrosive. Marketed as Q.A.I., the product is soluble in water base materials with a pH of 8.0 or higher and is composed chemically of 2 hydroxypropylamine nitrate. The inhibitor is incorporated directly into the manufactured product to be inhibited, and will in turn prevent oxidation or rusting by any surface active agent. Steel surgical instruments immersed for over three years in disinfectant solutions using Q.A.I. have shown no signs of corrosion. R. M. Hollingshead Corp.

219. New elastic rib belt

Made of a strong elastic band secured by webbing straps with adjustable buckles, belt offers an advantage over adhesive strapping in that it can be removed in an instant and eliminates skin irritation. Designed to provide perfect fit and firm support with maximum comfort. No metal touches the skin. Available in models for men and women. Special tailoring details in women's model include gussets in back to taper the belt and a cutaway to provide a comfortable breast opening. A. S. Aloe Co.

220. Measures blood temperature



A new hypodermic needle temperature pickup, capable of measuring temperature differences of as little as .001 degrees centigrade, has been announced by The Waters Corp. Extremely small (22 gauge) the pickups greatly reduce pain and injury. Sensitive tip of the needle is smooth and polished, with no broken surfaces, cracks or pinholes in which contamination can lodge. Electrical connection to needle is made through a shielded heat-resistant, waterproof, flexible cable to a detachable, locking-type connector. There are no permanently attached dangling leads. Unit is hermetically sealed; can be autoclaved.

221. New "indoor-outdoor" heating control

Maximum flexibility with simplified settings for easy adaptation to heating requirements of multiple occupancy buildings are features of a new "Weather-Man" control recently announced by Automatic Devices Co. Control has a remote outside-temperature sensitive bulb. The regulator case is installed indoors. Heat is controlled by a program dial which automatically controls heat input during the day, provides night setback and a morning buildup period—all adjusting according to the changes in the weather. A manual Variator dial can be positioned to variably increase or decrease the amount of heat flow in case of special requirements. Operates with all types of fuel in all classes of buildings.

222. "Tamed" iodine germicidal cleaner

Wescodyne, a new germicidal all-purpose cleaner for hospital use, contains "tamed" iodine—chemically stabilized and retaining all the well-known germicidal properties of iodine. Kills resistant varieties of bacteria and germs in matter of minutes. Sting, irritant and toxic properties have been reduced to where they no longer are limiting factor in iodine's usefulness as a germicide, manufacturers claim. Wescodyne visually indicates its own germicidal activity—has yellow-brown tint which persists as long as germicidal activity is assured. Effective in warm, cold and hard water. West Disinfecting Co.

223. Low priced polyethylene labware

A line of polyethylene laboratory ware at prices comparable to those asked for similar items made of glass is being offered by Pioneer Plastics. Polyethylene is said to provide practically unbreakable labware with excellent resistance to corrosion. Made of "Alathon" 10 polyethylene resin which affords maximum stiffness over a wide range of temperatures. First items in the line currently include a 250 milliliter low form beaker and cover, burette cover, and four funnels.

BUYER'S GUIDE

Continued

224. Vinyl latex exterior masonry paint

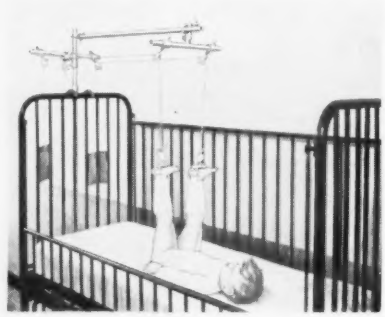
A new vinyl latex exterior masonry paint, called Spred Glide-On, is said to double the speed of painting and is extremely resistant to wear. The new Glidden paint offers owners of stucco, concrete block, and asbestos shingle buildings an outside finish with unusual resistance to fading, staining, peeling, mildew, and alkali reaction, according to the manufacturers. Also recommended for painting asphalt shingles. Spred Glide-On is a free flowing polyvinyl acetate emulsion that is said to dry to the touch within 30 minutes. May be applied quickly and easily with brush or roller. Flows rapidly and works quickly into the surface for a uniform appearance, free of brushmarks. Available in 12 colors. The Glidden Co.

225. Prevents slipping in the tub

A new odorless and invisible liquid called Nev-Er-Slip is said to assure protection against the "slipping in the tub" hazard. Supplied in an unbreakable plastic bottle, a few drops of the liquid squeezed into the bottom of tub or showerstall spreads into an invisible slip-proof film coating the entire surface. Water and ordinary soap will not affect film. Washes off easily with a detergent. Will not injure enamel. Nail-Do Corp.

226. New crib fracture set

The new Chick-Leinbach crib fracture set, recently announced by Gilbert Hyde Chick Co., can be used for all types of child tractions. Easy to store and simple to use, it fits any crib, metal or wood. Causes no damage to crib. Features include fast assembly; all angles of traction; swivel jointed pulleys; and interchangeable parts. Lightweight, neat appearing unit has few loose parts.



227. Anybed IV holder and bracket

Another Chick first, the Chick Anybed IV holder and bracket, can be used as an integral part of any Chick fracture frame without any extra parts. Center mounted — head or foot — the movable front bracket permits use from either side of bed. Friction lock assures steadiness. It is fully adjustable to any height; becomes a component part of the bed (does not go to the floor); eliminates tipping or breakage; attaches to any bed without harm; affords accessibility to patient in any position; and will not hit or mar furniture. Gilbert Hyde Chick Co.

228. Multiple audio-visual call system

This new system makes provision for any number of nurse control stations at different locations on the nursing floor. Permits the nurse who may be at the end of a long corridor, in the utility room or pantry, to identify and accept a patient call and carry on two-way conversation with patient without returning to main desk. Highly sensitive, the system can transmit the slight whispering or the weak breathing of very ill patients. Signals are automatically extinguished and reset for the next call once the call has been answered. Executone, Inc.

Upjohn

Bacterial diarrheas...

Kaopectate with Neomycin

Trademark, Reg. U.S. Pat. Off.

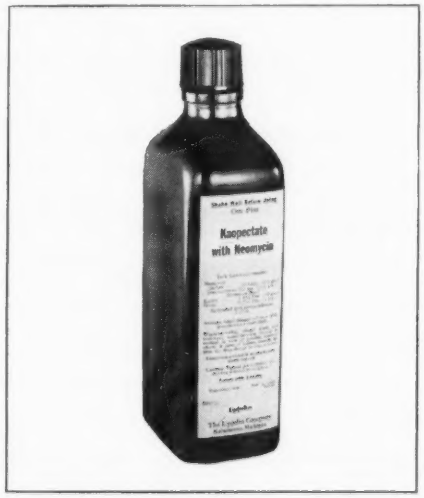
Each fluidounce contains:

Neomycin sulfate . . 300 mg. (4⅔ grs.)
[equivalent to 210 mg. (3¼ grs.) neomycin base]
Kaolin . . . . . 5.832 Gm. (90 grs.)
Pectin . . . . . 0.130 Gm. (2 grs.)
Suspended with methylcellulose . 1.25%

Supplied:

6-fluidounce and pint bottles

The Upjohn Company, Kalamazoo, Michigan



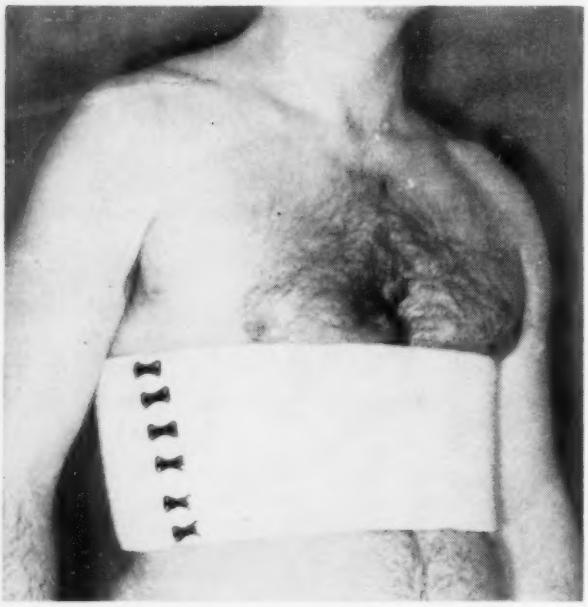
BUYER'S GUIDE

Continued

229. Leaky faucets stay fixed

New self-locking faucet washer screw is said to cut repair time, eliminate washer failure caused by faulty installation, and prevent time-waste of selecting exactly right-length screw to "set" against the bottom of screw hole. Ten sizes, carried in special "Handy Andy" metal box, do the job of 37 sizes. Made of corrosion-resisting Monel with a small nylon plug set into the shank. Plug grips the faucet spindle threads; screw can't work loose, won't ruin the washer, yet is easily removed and reuseable. Screw heads won't break off or burr when screw is removed. J. A. Sexauer Mfg. Co., Inc.

230. Elasticfoam pressure bandage



Made of purified foam rubber vulcanized to an elastic cotton bandage, Elasticfoam contains a series of multiple slits which allow the bandage to maintain an even, balanced pressure throughout its application. Foam rubber allows a pumping action in use and offers excellent protection. Will not slip even on a thigh. Non-slip, velvet-soft, and constant-pressure qualities make it especially useful in the treatment of varicosities and varicose ulcers, sprains and strains, back injuries, chest injuries and pleuritic pain, dislocations and fractures. Is highly absorbent and may be washed and autoclaved. Connecticut Bandage Mills.

231. New spray paint remover

Extra fast-acting Blister-Off spray paint remover causes hundreds of tiny "blisters" to form on paint, rising completely and cleanly from the surface, ready to be wiped or scraped off. One application is all that's needed, except for exceptionally stubborn cases, according to its manufacturer, The Wilbur & Williams Co. Supplied in 12-oz. containers.

232. New Tamp waste receptacle

The Tamp waste receptacle features a built-in automatic tamping device which permits a load capacity of up to 40 times more than that of conventional receptacles, according to its manufacturer, Pet Metal Products Corp. Light pressure of the foot on a treadle at the base of the receptacle raises the tamper while opening a door into which the waste is dropped. When the treadle is released, the waste is automatically tamped down and "baled" in a container which is readily removed for convenient disposal without the hands touching the contents. Available in three sizes.

233. Cleans floors quickly, reduces labor costs

Fullclean, a synthetic detergent, cleans floor in just one application and one rinsing. Highly concentrated, the product is dissolved in water in varying amounts, according to degree of strength needed for particular job to be done. Is equally effective on wood, concrete, terrazzo, linoleum, asphalt, or tile composition surfaces. Soil, oils or wax held in suspension will not redeposit. No film is left on the floor. Effective in either hard or soft water. Fuller Brush Co.

234. Non-spotting flat wall enamel

Alki-Therm is a new odorless flat wall paint based on a combination of glycerine alkyds and thermolyzed oils. Its principal feature is that it is non-spotting—there is no difference in color and sheen apparent after painting a wall containing both sealed and porous sections. The paint's ability to cover a porous wall and not seep in is attributed to the alkyd base; its flexibility and easy brushability is attributed to the thermolyzed oils. Product requires a minimum of surface preparation, resists chipping and scarring, and can be washed repeatedly. O'Brien Corp.

OUR 55 th YEAR

235. Infant surgery guide

An attractive 16-page catalog entitled *Weck Instruments for Infant Surgery,* describes and depicts Weck's complete set of instruments suitable for the more delicate or meticulous procedures required in infant surgery. Special features are the lists of suggested instruments for different types of infant operations, prepared by Edith Dee Hall, R.N., author of "Surgical Instrument Guide for Nurses," a manual widely used in teaching. Edward Weck & Co., Inc.

236. Victor equipment bulletin

A comprehensive bulletin contains complete specifications and illustrations of automatic manifolds, warning panels, signal lights, concealed outlets, vacuum bottle units, humidifiers, victrometers, two-stage regulators, and miscellaneous accessories. Victor Equipment Co.

237. Furnishings catalog

Royal's complete line of steel furniture for reception rooms, lounges, and dining areas is included in a new 26-page color catalog. Featured also is Royal's complete array of shelving and storage cabinets, and adjustable industrial stools and chairs for hospital laboratory use. Royal Metal Mfg. Co.

238. Classified equipment lists

Cenco bulletin No. 202 provides "at-a-glance" information on items and supplies required for equipping a 50-bed, 100-bed and 200-bed hospital. The items suggested are based on lists furnished by the U.S. Public Health Service, Division of Hospital Facilities and Division of Medical Resources. Equipment lists are classified into three groups—capital equipment usually specified in the construction contract; equipment that becomes depreciable after five or more years; and equipment that becomes depreciable within five years (usually low-cost items). Central Scientific Co.

239. Heart disease film

A 16 mm documentary film, *A Matter of Time,* showing the achievements of medical science in the fight against heart disease, is being made available on a free-loan basis to institutions and community organizations. The 15-minute color film shows such research developments as the "jiggle bed," oscillograph and the mechanical heart, with a simplified explanation of the causes and effects of various forms of heart disease. Association Films, Inc.

240. Heating systems catalog

A new 24-page catalog features a complete line of equipment for forced hot water heating systems and chilled water cooling systems. Included are nine pages of information on a complete line of circulating pumps for dozens of applications. Valves, fittings, air vents, air tanks and water heaters are also described in detail. Bell & Gossett Co.

241. Stainless steel equipment

Stainless Steel Equipment is the title of a new publication issued by Armco Steel Corp. for hospital administrators and department heads. Illustrated with photographs of actual installations, the bulletin describes what stainless steel is and where it is used. Several case histories of cost-savings are reported and a sample specification for casework is included. A handy reference chart shows which types and grades of stainless steel are used for all principal applications in hospitals.

economy
efficiency
and ease

with the MacBick

proven procedure for preparing

PARENTERAL SOLUTIONS in the HOSPITAL

The MacBick System Provides For:

- PRODUCTION OF INTRAVENOUS FLUIDS
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- PREPARATION OF HUMAN BLOOD PLASMA

. . . these three essential services backbone the remarkable utility of the famous MacBick Parenteral Solutions System . . . today acknowledged as having set the standard for modern hospital installations. Our Technical Department is readily available for individual consultations . . . please write or call

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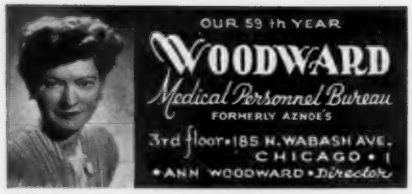
ORIGINAL DISTRIBUTORS OF THE FENWAL SYSTEM



Founders of the counseling service to the medical profession, serving medicine with distinction over half a century.

POSITIONS OPEN

ADMINISTRATORS: (a) Lay; gen hosp 400 beds affil med sch; unit impor med center; E. (b) Fairly lge gen hosp; excel med staff; Iowa. (c) Ass't; by med dir lge tch'g hosp; yng medical or non-med admin considered; very attrac city. (d) Medical; outstanding hosp 450 beds; unit impor tch'g center; E. (e) Lay, 1st ass't to med dir; lge hosp; med sch affil; req's B.S. w/good cost-acctng background; Pac Coast. (f) New gen hosp medium size; excel town, center finest hunting, fishing, boating; Pac NW. (g) Medical; gen hosp 200 beds; lge town; New England. (i) Lay; vol gen hosp 160 beds; very attrac county-seat, coll twn; E. (k) Fairly lge gen hosp; req's one, ACHA; Okla.

ADMINISTRATIVE EXECUTIVE POSTS: (b) Accountant qual develop into Bus Mgr; 4 hosp units, cap 400 beds; Calif. (c) Bus. Mgr; exp'd; sm gen hosp; to $6000; on Lake Michigan; univ med center. (e) Bus Mgr; outstand'g grp w/lge expansion program; man req'd late Spring; nr Chgo. (f) Comptroller: lge gen vol hosp affil med sch; nr Philadelphia. (i) Personnel Dir; very lge tch'g hosp; about $8000; lge city; univ med center. (j) Purchasing Dir; consider older male or female; hosp exp'd'g to 400 beds; twn 60,000; S.

ADMINISTRATORS-WOMEN: (a) Lay or RN; new 100 bd convalescent hosp; min $6000; univ med ctr; MW. (b) Lay or RN; vol gen hosp 150 bds; lovely coll twn; E. (e) RN; reorganize & admin univ nursing curriculum; to $7500; impor univ city; Central.

ANESTHETISTS: (a) By 2 MDs; Alaska. (b) 200 bd gen hosp; to $7000; nr univ city; MidE. (d) Chief; 300 bd hosp, expnd'g to 500 full mtce; lge city; MW. (e) Vol gen hosp 75 bds; $6000; attrac twn; Pac NW.

DIETITIANS: (a) Chief; vol gen hosp 200 bds; Boston area. (b) Therapeutic; new 250 bd gen hosp; lge univ city; MW. (c) District manager; 2 or more hosps; some travel; $6500 & expenses; E. (d) Chief; 200 bd gen hosp; attrac twn; NW. (e) Food serv mgr; apprv'd 250 bd gen hosp; MidE.

DIRECTOR OF NURSES: (a) Nurs serv; apprv'd 100 bd gen hosp; attrac twn; E. (c) Nurs serv; coll affil sch; 200 bd vol gen hospl to $6000, mtce; attrac twn 75,000; MW. (d) Dir of coll grad nurse prog; faculty rank; sm twn; S. (f) Nurs serv & ed; apprv'd 200 bd gen hosp; E.

FACULTY APPOINTMENTS: (a) Ed dir; gen hosp 200 bds; to $7500; E. (b) Nurse educator; faculty rank, coll affil school; min $6000; nr univ city; MW. (c) Science instr; 100 bd gen hosp; E. (d) Nurs arts, ped, & ob instr; fully apprv'd lge gen hosp; US dependency, tho cons tropical, climate mild; to $4200.

SUPERVISORS: (a) Supervisory RNs; grp studying long range effects atomic radiation; Japan (b) Ob; lge unit; new 300 bd gen hosp; nr NYC.

SITUATIONS WANTED

ANESTHESIOLOGIST: 31; Diplomate; 6 years, anes exper includ'g 2 yrs as chief, anes, hosp ship & 500 bed Naval hosp; pref twns under 50,000 in Wisc, Ohio, Penna, Mass, north or northeast.

ADMINISTRATOR: Medical; Dipl., Internal Medicine; five years, associate prof., medicine & med dir, univ hosp.

ADMINISTRATOR: B.Sc; 2 yrs, ass't dir, 2 yrs; acting dir, same univ hosp; early thirties; Nominee, ACHA

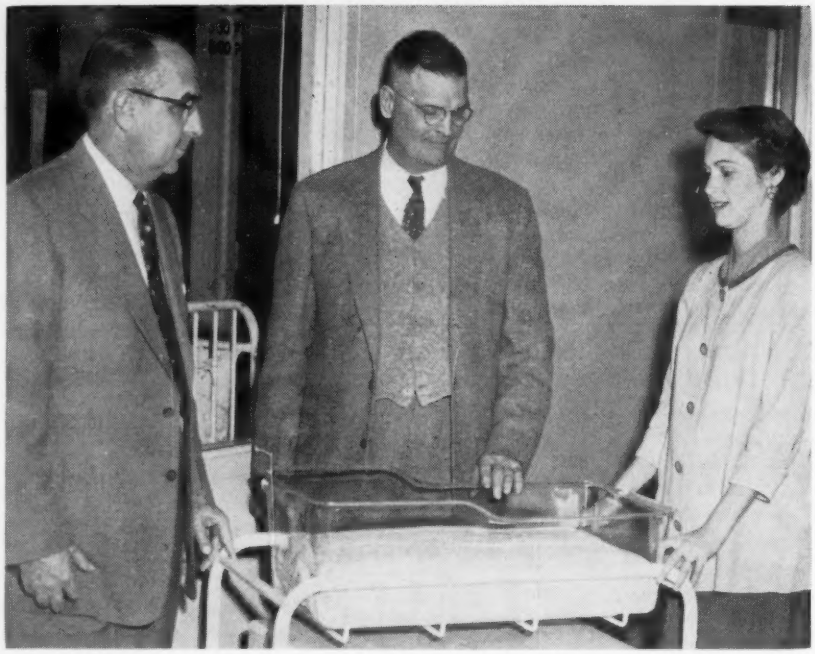
ADMINISTRATIVE ASSISTANT: 27; B.Sc, Acctn'g, U. Tulsa; M.H.A. (Chgo); years' adm residency, gen hosp 400 beds.

COMPTROLLER: 3 yrs, gen hosp 300 beds; Member, Nat'l Hosp Accountants Assoc; early 30's; immed available.

PATHOLOGIST: Dipl, both branches; 2 yrs, path, army hosp; 1 yr, faculty, med sch; 1 yr, dir, path, small hosp; age 31.

RADIOLOGIST: Dipl, both branches; 4 yrs, dir, path, 200 bed hosp; seeks larger hosp; highest recommendations.

Personally Speaking



America's first "Blue Cross baby," Mrs. Ann Woodard Reid, Chapel Hill, N. C., presents a bassinet to Watts Hospital, Durham, N. C.—the hospital in which she was born 21 years ago. The presentation was made on behalf of the Durham Blue Cross Plan Hospital Care Association as part of the opening of the recent nationwide 25th anniversary celebration of the Blue Cross idea. The bassinet was accepted for the hospital by Sample B. Forbus (c.), director. Also shown is F. Norman Bowles, M.D., Durham, who delivered Ann. It is estimated that, since Mrs. Reid's birth in 1933, some 12 million babies have been born and paid for under the nationwide Blue Cross program.

John A. Atchley, M.D.—has been named director, Salisbury (Conn.) Health Center. For the past five years he has been associate director, Child Guidance Clinic, New Canaan, Conn.

Donald C. Bilhorn—has resigned as assistant administrator, Truesdale Hospital, Fall River, Mass., to become administrator, John T. Mather Memorial Hospital, Port Jefferson, Long Island, N.Y.

Robert S. Cameron—has been named comptroller, Silver Cross Hospital, Joliet, Ill. He was formerly internal auditor for the Essex Wire Co., Fort Wayne, Ind.

James E. Crank—has been named assistant administrator, Jefferson-Hillman Hospital, Birmingham, Ala. He formerly was assistant to the director, Division of Local Health Organizations, Georgia Department of Public Health.

Thomas B. Fitzpatrick—assistant director, Pittsburgh (Pa.) Montefiore Hospital, will become administrator, New Kensington (Pa.) Citizens General Hospital, replacing **Olin L. Evans.** Mr. Evans plans to enter the field of consultation work in hospital planning and organization, after serving in hospital administrative capacities for more than 25 years.

Ralph H. Fouser, M.D.—of Chicago has been named assistant superintendent, Kankakee (Ill.) State Hospital.

William L. Gold—has been appointed administrator, Crippled Children's Hospital, New Orleans, La. He was previously administrator, Relief Society Hospital, N. M.

Lt. Col. Elizabeth T. Hanna—has been appointed chief, nursing service, Ft. Jackson (S. C.) Army Hospital. She was previously nursing consultant to the Eighth Army in Korea.

Anna G. Haviland—has joined the staff of Methodist Hospital, Pikeville, Ky., as head of the dietary department. She was formerly at Florida Southern College, Lakeland, Fla.

Sister Hermine—Daughters of Charity, St. Vincent de Paul, has been appointed administrator, St. Mary's Hospital, Milwaukee, Wis., to succeed **Sister Rose.** Sister Hermine has been assistant to Sister Rose for the last nine years. Sister Rose will be in

(Continued on page 58)

BUYER'S GUIDE Information Service

201. Fast, simple micro-projector.
202. Electronic oven reduces cooking time.
203. Floor patch for any type floor.
204. Tote basket for bussing dishes.
205. Hot distilled water always on hand.
206. Convert bathtub into whirlpool bath.
207. Electric adding machine for hospital accounting.
208. Flashball tells when you're in the vein.
210. Ram rod for clearing plumbing.
211. Micro-organisms destroyed with room air sterilizer.
212. Dusting and polishing cloth durable, disposable.
213. Vertical shelving with snap-in dividers.
214. Grease stains removed with aerosol product.
215. Projection type weight indication.
216. Stainless steel, bronze, aluminum metal work.
217. Rubber syphon and hand pump.
218. New corrosion inhibitor for metal instruments.
219. Elastic rib belt can be removed without irritation.
220. Hypodermic needle temperature pickup.
221. Maximum flexibility in new heating control.
222. Germicidal all-purpose cleaner.
223. Corrosion-resistant polyethylene labware.
224. Vinyl latex paint doubles painting speed.
225. Liquid protects against slipping in tub.
226. Crib fracture set for child tractions.
227. Anybed IV holder and bracket.
228. Audio-visual call system.
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239. Film shows achievements against heart disease.
240. Catalog on heating systems.
241. Bulletin on stainless steel equipment.

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First Class Permit No. 34341, Sec. 34.9, P. L. & R., Chicago, Illinois

HOSPITAL TOPICS

30 West Washington Street

Chicago 2, Ill.

Send more information on items circled. FEBRUARY, 1955

201.	207.	214.	220.	226.	232.	233.
202.	208.	215.	221.	227.	233.	239.
203.	210.	216.	222.	228.	234.	240.
204.	211.	217.	223.	229.	235.	241.
205.	212.	218.	224.	230.	236.	
206.	213.	219.	225.	231.	237.	

Other information

Name _____ (Please Print) Position _____

Hospital _____

Address _____

City _____ Zone _____ State _____

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HOSPITAL TOPICS
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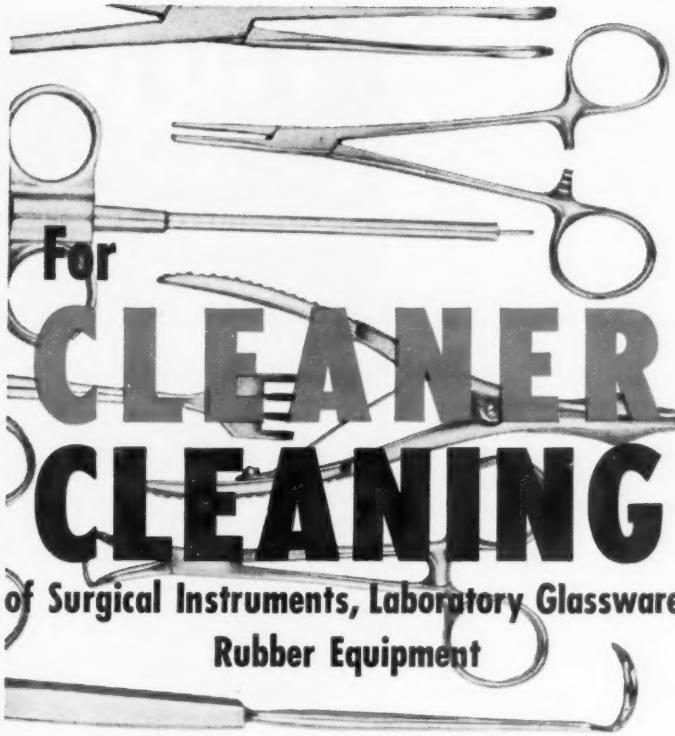

For CLEANER CLEANING

of Surgical Instruments, Laboratory Glassware, Rubber Equipment

WECK CLEANER

—offered by an INSTRUMENT MANUFACTURER

Read these facts about this revolutionary new Cleaner and COMPARE!

After years of research, Weck introduces WECK CLEANER with the assurance that there is no finer instrument cleaner on the market. Here are the FACTS about this revolutionary new product:

- **Removes clotted blood and other contamination rapidly.**
- **Cleans effectively even in the hardest water.**
- **Wets, penetrates, dislodges and emulsifies all soils rapidly.**
- **Dissolves rapidly in warm water.**
- **Does not produce foam which would interfere with mechanical washing.**
- **Inhibits corrosion of surgical instruments.**
- **Completely safe to use. Does not contain free caustic. No more alkaline than a neutral soap.**

We suggest that you order a 5 pound can of WECK CLEANER. If you are not more than satisfied with the results we will gladly refund your money.

PRICES PER 5 LB. CAN WITH MEASURING SPOON:	
1 can	$5.30
3 cans	5.00 each
6 cans	4.80 each
12 cans	4.60 each

*Remember—***WECK** *is world-famed for Surgical Instrument Repairing*

If you ask me—
any product that will clean thermometers and formula bottles and nipples will clean anything. And, in my opinion, the best job is done by the new WECK CLEANER.

Founded 1890

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135 JOHNSON STREET • BROOKLYN 1, N. Y.
Manufacturers of Surgical Instruments • Hospital Supplies
Instrument Repairing

CLASSIFIED

SHAY MEDICAL AGENCY

Blanche L. Shay, Director

Pittsfield Bldg., 55 E. Washington St.

Chicago 2, Illinois

POSITIONS OPEN

EXECUTIVE PERSONNEL: (a) Executive Director. 245-bed hospital. Require some experience in administrative position. $10,000, plus living quarters. (b) Business Manager. 50-bed hospital fully approved. Modern in all respects. (c) Personnel Director. Middle West. Large hospital. Require good training in personnel. $8,000-$10,000. (d) Comptroller. Middle West. 400-bed hospital. 3 years accounting or business manager experience. $7,000 minimum. (e) Business Manager. East. 25-man medical group; well established. Excellent opportunity. $6,000-$8,000. (f) Personnel Director. 300-bed general hospital. Set up and administer personnel management program for about 500 employees. (g) Business Manager. Northwest. 200-bed hospital; also do purchasing. $5,000.

MEDICAL WRITER: East. Large pharmaceutical company. Require mimimum of 5 years' writing experience in pharmaceutical and drug field. $6,000-$8,000.

DIRECTORS OF NURSING: (a) East. 300-bed hospital. Complete charge of nursing service and nursing education. Beautiful new hospital; B.S. degree required. $7,200. (b) East. 225-bed hospital; personnel in department numbers about 160. Excellent nursing school. $6,000-$7,200 plus an exceptionally attractive suite of rooms. (c) Southwest. 130-bed hospital located in university city. 50 students in nursing school; accredited. $6,000. (d) Middle West. 100-bed hospital in city of 35,000. Unusually stable staff of assistants; 48 full-time R.N.'s and comparable number of aides. $7,200. (e) Assistant Director Nursing Education. 175-bed hospital located in eastern city of about 20,000. 45 students in nursing school. $6,000.

MARY A. JOHNSON ASSOCIATES

AGENCY

11 West 42 Street, New York 36

Longacre 3-0764

Mary A. Johnson, Ph.D., Director

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

charge of the hospital's expansion program.

Sister Mary James Hovan, V.S.C.—has been appointed administrator, St. Vincent Hospital, Monett, Mo. She has been associated with the hospital since 1946.

Herbert M. Krauss—former administrator, Burlington (Ia.) Hospital, has been appointed administrator, Latrobe (Pa.) Hospital.

Conrad O. Ranger, M.D.—assistant state mental hygiene commissioner, has been named superintendent, Rollman Receiving Hospital, Cincinnati, O. He succeeds **H. K. Moir, M.D.**, who has become superintendent, Massillon (O.) State Hospital. Dr. Moir replaces **Arthur G. Hyde, M.D.**, who retired.

Dan Snow—has been named acting administrator, Henry County General Hospital, Paris, Tenn. He succeeds **Joe Taylor** who has resigned to accept an administrative post with the Tennessee Department of Mental Health. Mr. Snow was formerly administrative assistant at Henry County General.

William H. Somers, M.D.—has been appointed associate radiologist, Macon (Ga.) Hospital. He will assist in setting up the isotope laboratory and cobalt unit.

George G. Sprague—has been advanced from credit manager to assistant superintendent, Silver Cross Hospital, Joliet, Ill.

Robert S. Summers—has resigned as business manager and assistant administrator, Charleston (W. Va.) Memorial Hospital. He has accepted an appointment as comptroller, Memorial Hospital, Savannah, Ga.

Thomas T. Tourlentes, M.D.—of Chicago was appointed assistant superintendent, Galesburg (Ill.) State Research Hospital.

VA Appointments

Arnold A. Schillinger, M.D.—chief of professional services, VA hospital, Montrose, N.Y., has been appointed manager of the neuropsychiatric VA hospital, Northport, Long Island. He succeeds **Roger P. Hentz, M.D.**, who is retiring after more than 32 years of government service.

Rhobia Taylor—who has been on loan for the past year to the VA Nursing Service as special assistant to the director for overall planning of nurse recruitment, has returned to the National League for Nursing, New York City.

CONTROLS UNUSUALLY HIGH TEMPERATURES

For Days, Weeks or Months. Patient rests on or is wrapped in resilient blanket, through which is pumped ice water at a constant, uniform 38° to 40°F., or in extreme cases can be encased between two such blankets.

Patient is not disturbed with frequent replacement and readjustment of ice bags, with alcohol sponges, etc.

Usually only underblanket required. Each Unit will service two blankets. In a Hypothermia Room several Units can be supervised by a single nurse.

Blankets made of 2 layers of washable, rubberized fabric with channelized continuous rubber tubing running between them. Various sizes available.

One charge of ice lasts 10 to 12 hours. No intricate mechanical problems. Only moving part a dependable motor-driven pump.

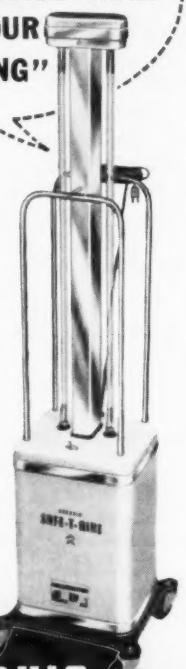
For Catalog Write to:

THERM-O-RITE PRODUCTS CORP.

Originators of Hypothermia Equipment

1748 Main Street Buffalo 8, N. Y.

LESS THAN 1 HOUR IRRADIATION MORE EFFECTIVE THAN USUAL 24 HOUR "AIRING"



EXTRA SAFETY FOR YOUR PATIENTS **. . . EXTRA** SAVINGS IN TIME AND MONEY

HANOVIA
SAFE-T-AIRE
PORTABLE ULTRAVIOLET AIR STERILIZER

The Hanovia Portable Room Air Sterilizer permits prompt re-use of contaminated areas. In just 30 minutes of irradiation following clean-up procedures, Hanovia's Portable Safe-T-Aire Sterilizer disinfects the average vacated two-bed room making it available for immediate re-occupancy.

Important, too, is the fact that Hanovia's mobile Safe-T-Aire Sterilizer wheels quickly, easily from room-to-room on noiseless casters. Hundreds of hospital administrators and directors appreciate the value of this practical unit as a final precaution in the clean-up of operating rooms, children's clinics, isolation, autopsy, cystoscopy and emergency rooms and laboratories.

WRITE TODAY for free brochure detailing benefits secured by use of Hanovia Portable Safe-T-Aire units. No obligation, Dept. HT-2.

HANOVIA Chemical & Mfg. Co.
100 Chestnut St., Newark 5, N. J.

50th Anniversary
HANOVIA WORLD LEADER
IN ULTRAVIOLET FOR HALF A CENTURY

W. Taliaferro Thompson, Jr., M.D.—has been named chief of medical service, McGuire VA Hospital, Richmond, Va. He succeeds the late **John Powell Williams,** who died last September. Dr. Thompson has also been promoted to associate professor of medicine at the Medical College of Virginia.

Merle W. Allen—has been named assistant manager, VA hospital, Boise, Idaho.

Deaths

Joseph L. Baer, M.D.—74, senior attending obstetrician and gynecologist and former chief of staff, Michael Reese Hospital, Chicago, died December 8.

Raymond L. Barrett, M.D.—60, Springfield, Mass., physician for more than 30 years, and lieutenant colonel in the Medical Corps in World War II, died December 10. He had been attending physician at Springfield (Mass.) Hospital, and a consultant in gastroenterology, Springfield Health Department Hospital, and Cooley Dickinson Hospital, also in Springfield.

Louis Bauman, M.D.—74, former assistant attending physician and assistant professor of internal medicine, Columbia-Presbyterian Medical Center, New York City, died November 1.

Pliny R. Blodgett, M.D.—62, physician and surgeon in Chicago Heights, Ill., for 38 years, died December 20. He was past president, Illinois Academy of General Practice, and former chief of staff, St. James Hospital, Chicago Heights.

Ludwig A. Boehmer, M.D.—56, surgeon, Mary Immaculate Hospital, Jamaica, Queens, N.Y., died recently.

Robert R. Chace, M.D.—44, assistant ophthalmologist and instructor in ophthalmology, Columbia-Presbyterian Medical Center, New York City, died November 24. He was a consultant to the division of vocational rehabilitation, New York State Department of Education, and a staff member of the Lawrence Hospital, Bronxville, N.Y.

Charles F. Daniels, M.D.—39, thoracic surgeon, died December 8 in New York City. He had been an associate of John Maxwell Chamberlain, M.D., in thoracic surgery. Together they designed the Chamberlain-Daniels vacuum pump.

John Eiman, M.D.—67, pathologist,

(Continued on next page)

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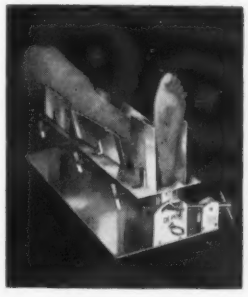

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died December 3. He was director of laboratories, Abbington Memorial Hospital, Philadelphia, for 20 years.

E. G. Faber, M.D.—58, former chairman of the medical board, Medical Center Hospital, Tyler, Tex., and former clinical assistant professor of medicine, Southwestern Medical School, Dallas, Tex., died on December 8.

Charles M. Griffith, M.D.—72, medical director of the Veterans Administration from 1931 to 1945, died December 20 in Washington, D.C.

Lewis R. Hill—58, pathologist, St. Anne's Hospital, Chicago, died December 15.

Milton A. Juster, M.D.—46, retired army surgeon, died December 25. He was associated with French Hospital, New York City.

Ruth Woodworth Keerps—dietitian at Bellevue Hospital, Butler, Pa., died December 12.

George K. Levan, M.D.—77, practicing physician in Reading, Pa., for 47 years, died December 10. He formerly was medical staff chief, St. Joseph's Hospital, Reading.

Isaac Harris Levy, M.D.—76, urologist and member of the staff, Lenox Hill Hospital, New York City, since 1917, died December 16.

Jere John McEvilly, M.D.—56, Little Falls (N.Y.) health officer and school physician, died December 20. He was past president of the Little Falls Hospital staff.

Warren C. Mercer, M.D.—83, Philadelphia obstetrician and gynecologist for 53 years, died December 17.

Bernard Milch, M.D.—49, specialist in general and traumatic surgery, Jewish Memorial Hospital, New York City, died December 16.

Clement J. Molony, M.D.—45, pediatrician, died December 4 in Los Angeles. He was past president, Southwestern Pediatric Society.

J. F. Norman, M.D.—74, founder of the Crookston (Minn.) Clinic, died November 29.

Ann S. Nyquist—66, chief, public health nursing section, Minnesota State Health Department, died December 8. She was one of the state's top leaders in the public health nursing field.

Walter Phelan, M.D.—59, Elizabeth, N. J., surgeon, died December 24. He was president of the medical board and attending surgeon, St. Elizabeth's Hospital, Elizabeth, and member of the staffs of Elizabeth General and Alexian Brothers hospitals in Elizabeth.

Frederick A. Rettig, M.D.—57, attending staff surgeon, Alexian Brothers and St. Joseph hospitals, Chicago, died December 13. He was a former president of the Alexian Brothers hospital staff.

Sister Rosanna—89, died at St. Vincent's home, Seattle, Wash., recently. She had been superior of various hospitals in Washington and Oregon operated by the Sisters of Charity of Providence. She was in her 70th year of religious life.

Philip S. Rosenblum, M.D.—60, medical director and chief of urology, Eastern Division of the Einstein Medical Center, Philadelphia, died December 12.

William Saltzman—88, retired osteopath, Benton Harbor, Mich., died December 24. With his son he operated the Saltzman Sanitarium and Hotel, Benton Harbor.

Hunter Scarlett, M.D.—69, ophthalmologist and former all-American football player with the University of Pennsylvania, died December 23. He was ophthalmologist at Bryn Mawr (Pa.) Hospital from 1921 to 1940, and consulting ophthalmologist until his

Among the guests at a recent party celebrating the consolidation of Becton, Dickinson & Co. and Wilson Rubber Co. were (l. to r.) Fred S. Greenhut, Crosby B. Washburne, Jr., and Myron J. Ripp, salesmen for The J. F. Hartz Co., Ferndale, Mich.; Mrs. Ferdinand Cinelli; Mr. McCullough, vice president and assistant general manager, The J. F. Hartz Co., Ltd., Toronto, Canada; Ferdinand Cinelli, president, The J. F. Hartz Co.; Albert H. Hemmingsen, J. F. Hartz Co. salesman; and Mrs. Hemmingsen. The celebration was held in Chicago during the recent American Surgical Trade Association meeting.

death. He was associate ophthalmologist, Pennsylvania Hospital, Philadelphia.

Frances I. Seymour, M.D.—54, New York City specialist in sterility and eugenics, died December 17. She was a leader in the field of artificial insemination. In 1940 she organized the National Research Foundation for Fertility.

John J. Sheedy, M.D.—51, eye, ear, nose and throat specialist, Plainfield, N. J., died December 7.

Albert S. Snell, M.D.—83, eye specialist, Rochester, N.Y., for 55 years, died December 9.

George Birch Stanwix, M.D.—78, eye, ear, nose and throat specialist for more than 50 years, died December 24. He was on the staff of Yonkers (N.Y.) Professional Hospital and Yonkers General Hospital. He was formerly on the staff, St. Joseph's Hospital, Yonkers, and Roosevelt Hospital, New York City. He was former consultant, Polyclinic Hospital, New York City.

Robert H. Stein, M.D.—chief cancer research breast surgeon, Roswell Park Memorial Institute, Buffalo, N.Y., died December 7.

Ellis Studebaker—former administrator, Bethany Hospital, Chicago, died December 4.

Wallace B. Tracy, M.D.—75, resident physician, Toledo (O.) State Hospital, died December 6.

Radiological Societies Elect Officers

J. Marsh Frere, Chattanooga, has been named president of the Tennessee Radiological Society.

Other new officers are John M. Wilson, Memphis, vice-president; and George K. Henshall, Chattanooga, secretary-treasurer.

New officers of the Central Ohio Radiological Society, which also had a recent election, are George F. Jones, Lancaster, president; Howard W. Bangs, Columbus, vice-president; and Arthur R. Cohen, Columbus, secretary-treasurer.

Hospital Purchasing Workshop Planned

A workshop on hospital purchasing, sponsored by the Association of Western Hospitals, will be held February 10-11 at the Mark Hopkins Hotel, San Francisco.

Highlights of the program will include a discussion of the purchasing agent's relation to operating departments, as contrasted to administrative departments. Standardization of purchases will also be discussed.

Einstein Medical Center Dedicates New Lab

Formal dedication of a new microchemical laboratory, which makes possible chemical analysis of blood constituents from a single drop of blood, was held recently at Albert Einstein Medical Center, Philadelphia.

The new micro-chemical equipment was presented to the medical center by the Pannonia Beneficial Association in honor of Dewey Smith, secretary-treasurer of the group for many years.

The special micro-apparatus permits obtaining of results of an accuracy comparable to those obtained by standard methods using much larger quantities of blood, according to Pascal F. Lucchesi, M.D., executive vice-president and medical director of the center. The new equipment is especially useful in pediatrics.

Henry E. Marks Heads Diabetes Association

Henry E. Marks, M.D., associate in medicine, Columbia University, was elected president of the New York Diabetes Association at the annual meeting of the association's board of directors.

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Anti-$Rh_0{}''$ (Anti-DE) (Slide or Rapid Tube), 2 cc.
Anti-rh'' (Anti-E) Typing Serum (Slide or Rapid Tube), 2 cc.
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Anti-rh' (Anti-C) (Saline Tube), 2 cc.
Anti-hr' (Anti-c) (Slide or Rapid Tube), 1 cc.
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Anti-N Typing Serum (Rabbit), 2 cc.

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VDRL Antigen (with 60 cc. diluent), 5 cc.

OTHER DIAGNOSTIC REAGENTS
Anti-Human Serum (for Coombs Test), 2 cc., 5 cc.
AB Serum, 5 cc, 20 cc., 100 cc.
Human Albumin, 30% Solution, 5 cc., 50 cc.
Bovine Albumin, 30% Solution, 5 cc., 50 cc.
Albumin-Serum Conglutinin (Human), 10 cc.
Anti-Human Precipitin Serum (to detect human blood), 1 cc.

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Patient Care Group Headed by Doctor

Clark C. Goss, M.D., Seattle physician, has been elected chairman, Washington State Joint Commission for the Improvement of the Care of the Patient.

Miss Vera Meeker, director of nursing, Deaconess Hospital, Spokane, was named vice chairman.

Mrs. Cecile Tracy Spry, administrator, General Hospital, Everett, and Robert Beaumier, personnel director, State Health Department, are secretary and treasurer respectively.

Gorgas Medal Awarded to G. Robert Coatney

Dr. G. Robert Coatney, U.S. Public Health Service, was awarded the 1954 Gorgas medal by the Association of Military Surgeons for his "outstanding contributions to the chemotherapy of malaria." The award was made at the association's recent annual meeting in Washington, D.C.

The medal is awarded annually to a person who has distinguished himself by his contribution to military medicine. Dr. Coatney is chief of the chemotherapy section of the Laboratory of Tropical Diseases, National Institutes of Health.

Crippled teen-agers in the Los Angeles Orthopedic Hospital are learning to cook and keep house in a modern kitchen equipped with the latest gas refrigerator, range and washer-dryer. Here 17-year-old Deanna Coats (r.) is preparing breakfast bacon with the help of Connie Fortney, occupational therapist in the hospital's new rehabilitation wing. Two gas utility companies and three gas appliance manufacturers cooperated in designing and equipping the kitchen.

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Scholarships Now Available In Medical Library Work

The Medical Library Association is offering four scholarships of $150 each for summer school courses in medical library work in 1955, two at Columbia University, New York City, and two at Emory University, Atlanta, Ga.

Applications for the scholarships should be made to the school at the time of application for enrollment. April 1, 1955, is the association's closing date for scholarship applications and candidates must already have been accepted by the school.

Completion of either course will enable a student with a bachelor's degree and one year's library school training to qualify for Grade I certification by the association.

The course at Columbia University is offered July 5 to August 12. Emory University offers its course July 18 to August 20.

Clearing House Planned For Blood Bank Exchange

Plans for a regional clearing house to facilitate the exchange of credits between blood banks in 11 midwestern states, have been announced by the Illinois State Medical Society.

Through this clearing house, a person living in Michigan could go to the blood bank nearest his home and donate blood for a friend in Chicago. In most instances the transfer would be a bookkeeping operation.

The medical society, which has appropriated $6,000 to establish the clearing house, said that under the plan balances would be corrected with transfers of actual blood.

The clearing house, according to the announcement, is to be established in Chicago under the auspices of the American Association of Blood Banks, which has planned four other regional clearing houses covering the entire country.

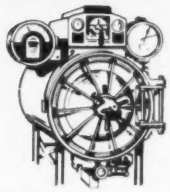
Medical Social Work Scholarship Awarded

The first scholarship for advanced study and training in medical social work in a hospital was awarded recently to Clare Yoder at a meeting of the Social Service Committee of the Medical Board, Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City.

Funds for new scholarships were given by the Gustavus and Louise Pfeiffer Research Foundation for medical social work which stresses problems of illness and hospitalization on the individual or family level.

Miss Yoder is a supervisor of case work in the social service department of Presbyterian Hospital.

New Autoclave Indicator Tape



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changes color during the autoclave procedure*

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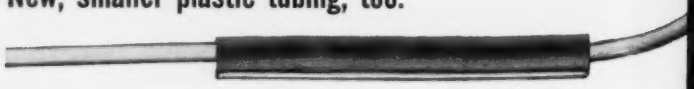

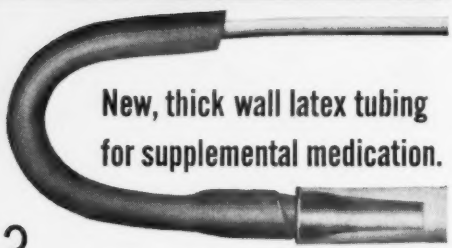

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Long Beach Nurses Form A.O.R.N.

Organizational group of the recently formed Long Beach, Calif., Association of Operating Room Nurses are, front row, (l. to r.): B. Asnoux, St. Mary's Hospital; Bernice Ginrich, Hawthorne Community Hospital; Phyllis Jensen, Long Beach Community Hospital; Sally Sills, San Pedro Community Hospital; Marie O'Koren, Seaside Hospital, Long Beach; and Mrs. Ethel West, Methodist Hospital, Los Angeles. Mrs. West, who is president of the Los Angeles A.O.R.N., was the guest speaker at the initial meeting.

Back row: Mrs. Virginia Coulter, Magnolia Hospital, Long Beach; Mrs. H. Anderson, VA Hospital, Long Beach; Dorothy Wright, Hoag Memorial Hospital, Newport Beach; Dolores Wagner, Harriman-Jones Hospital, Long Beach; Betty Parrish, Hoag Memorial Hospital, Newport Beach; Sue Grayson, Harbor General Hospital, Torrance; Gwen Barnett, VA Hospital, Long Beach; Florence T. Lynch, Long Beach General Hospital; and Mrs. Ruth Cooper, St. Mary's Hospital, Long Beach.

The O.R. Recovery Room . . .

A Symposium

Recovery room unit at new Bernalillo County-Indian Hospital, Albuquerque, N. M. (see story on page 14), instead of being in separate room, is in wide hall just opposite operating room supervisor's desk. Entire unit, or individual beds, may be curtained off for privacy, or curtains may be pulled back, so that nurse on duty on O.R.S.'s desk can also keep an eye on patients. Dorothy Palkovic, R. N., recovery room nurse, is shown in unit. Idea for arrangement came from Sweden.

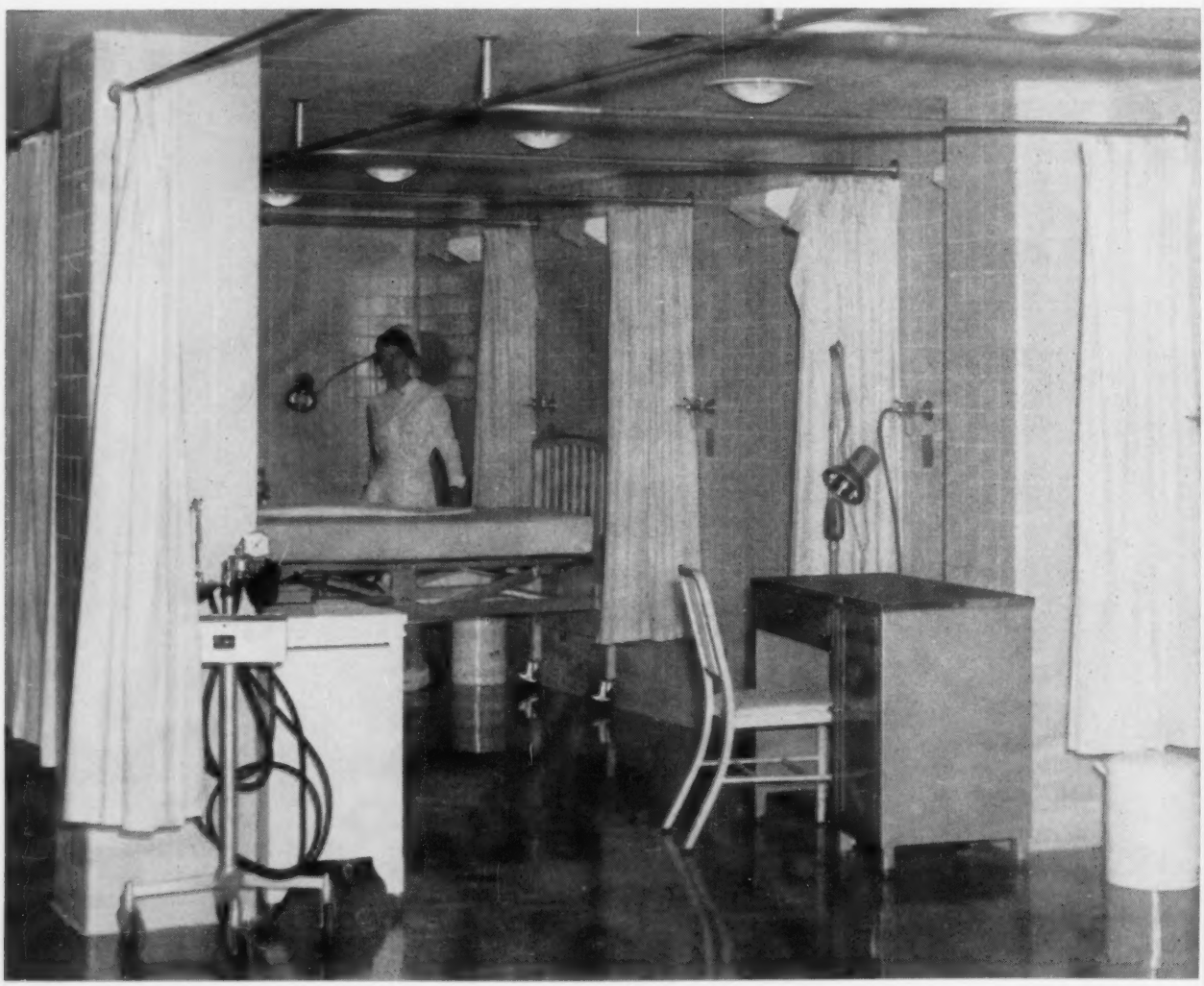
What is the Educational

By Sister St. Bernadette, S.M., R.N.
Director of Nurses
Misericordia Hospital School of Nursing
New York City

(Abstract of a dissertation, "A Study of the Existing Educational Value in the Assignment of the Student Nurse to the Recovery Room," submitted to the faculty of the School of Nursing Education, the Catholic University of America, in partial fulfillment of the requirements for the degree of Master of Science in Nursing Education.)

BECAUSE of the acute shortage of nursing personnel during and after World War II, care of the postoperative patient has been a difficult problem in many hospitals. Caring for these patients in central recovery rooms was found to be one of the most efficient and safe means of furnishing the necessary care of the postoperative patient.[1]

The purpose of our study was to determine the educational value of the recovery room in the assignment of student nurses. While the advantages of the recovery room from a nursing service standpoint are known, there is no



Value of Recovery Room Assignment?

evidence that its educational value in the instruction of student nurses has been studied.

For the study, we defined the recovery room as follows: A recovery room is a special observation room to which postoperative patients recovering from anesthesia are taken for immediate postanesthetic and postoperative care under skillful supervision.

From experiences acquired in both the administration of anesthesia and several years of contact with student nurses on the surgical ward, we observed that student nurses encounter many problems in caring for the postoperative patient. Because of these observations, we assume that there is a need for a more intensive and carefully planned experience for the student nurse in this particular aspect of nursing care. This assumption is based on several tragic incidents in our experience with student nurses, two of which will be considered here.

In one instance, the student nurse showed a definite lack of knowledge in caring for the anesthetized patient. Alarmed at the partial respiratory obstruction of a postoperative patient, she left the room to summon help. In the meantime, cyanosis had developed to an alarming degree. The simple procedure of supporting the jaw is all that would have been required to achieve a clear airway and spare the student from an emotional shock.

On another occasion, a student nurse had been taught to lower the shade before the patient returned to his room. Attributing the change of the patient's color to the dimness of the room, she sat there confident that everything was all right. Contrary to his practice, the attending physician stopped on the surgical ward to check his patient before he left the hospital. A glance at the patient revealed the sad situation. Emergency measures were instituted with no avail. The student nurse, as a result, left nursing, a career she had cherished since childhood.

Student nurses frequently are reticent in expressing their difficulties because of fear of criticism and the embarrassment they experience in acknowledging their inadequacy. Such obstacles lessen a student's confidence in her own capacity to acquire skill. The student nurse develops a negative attitude toward the postoperative patient and avoids care of this patient whenever possible. These feelings of apprehension and insecurity result in undesirable reactions detrimental to both patient and student.

We believe that provision for skillful supervision of the student nurse's experience in the care of the postoperative patient would eliminate much of the emotional trauma experienced by the student when caring for the anesthetized patient. The student would, therefore, develop a more wholesome attitude and a feeling of assurance in her ability to handle efficiently any emergency measures that she would be called upon to perform.

The Anesthesia Study Commission of the Philadelphia County Medical Society said in a report, "Bad Training in Anesthesia Deaths Told," that an 11-year investigation of 306 anesthesia fatalities in that area disclosed that 47 percent of the deaths could have been prevented. The highest preventable death rate covered by the report totaled 54 percent and occurred among a group of 97 patients whose preoperative condition was listed as good.[2]

From these statistics, it is evident that the nurse must assume a very important role in the care of the postoperative patient and must, therefore, be given adequate theory and carefully supervised practice in the management of the postoperative patient.

The fact that patients occasionally have gone into shock after returning from the operating room in apparently good condition, has led us to believe that all patients should have the same skillful supervision postoperatively, regardless of their condition on leaving the operating room.

Would the recovery room be the ideal laboratory which would bridge the gap between theory and practice in the care of the postoperative patient? Because of inadequate supervisory personnel on the ward, teaching opportunities frequently are not converted into learning situations.

METHODS OF STUDY

A survey of literature pertinent to the study gave no evidence that previous work had been done in this field. However, the need for nurses better prepared in this aspect of patient care has been mentioned frequently by experts in the field of anesthesia.[3]

Since literature was not available, the study was conducted by means of observation and personnel interview, a card questionnaire, and a more comprehensive survey questionnaire. Observations were conducted in four hospitals with an active recovery room service. At each hospital, interviews were held with the director of nurses, and, in three of the hospitals, with the chief anesthetist. Emphasis was placed on securing the following information:

1. Location of the recovery room
2. Administration of the room
3. Types of patients taken there
4. Equipment and facilities available
5. Types of activities performed in the room
6. The existing educational program for the student nurse during her experience in the recovery room.

As the next step, a card questionnaire was mailed to 1,450 hospitals with bed capacity of 100 and over, and 1,000 responses were received. Purpose of this questionnaire was to determine the distribution of recovery rooms and whether there were enough to justify the study.

Finally, a detailed questionnaire was sent to 81 schools of nursing which were connected with hospitals having an active recovery room service. Material in the questionnaire was based on information gathered in the previous steps of the study, as well as on our personal experience in the field. Of the 81 schools polled, 42 responded.

ANALYSIS OF DATA

Of the 1,000 hospitals replying to the card questionnaire, 129 had a recovery room service. Of these, 81 were connected with schools of nursing. In addition, 239 hospitals reported that they were in the process of developing a recovery room or were planning to establish one. This would indicate an increase in the number of hospitals offering such a service.

Part I of the detailed questionnaire was designed to give information relative to the administration of the recovery room. Of the 42 hospitals participating in the study, 30 had their recovery room service under the control of the nursing school office. This type of relationship

(Continued on next page)

[1]Shupp, Miriam G., "Panel Discussion," **The Bulletin of the American Association of Nurse Anesthetists**, Vol. X, No. 4, November, 1942, pp. 261-72.

[2]Anesthesia Study Commission, "Bad Training in Anesthesia Deaths Told," **Chicago Daily Tribune**, December 8, 1947.

[3]Lundy, S. A., "Nursing Care as Related to Anesthesia," **American Journal of Nursing**, August, 1944, p. 747.

would facilitate a program whereby the student nurse gains practical experience in the recovery room.

Part II of the questionnaire was designed to determine how many recovery rooms were located close to operating rooms and to the anesthesia department. The advantage to the student in this arrangement is that necessary emergency equipment not kept in the recovery room, is nevertheless, easily available. Also, availability of the surgical and anesthesia staffs is invaluable to the inexperienced student. The survey revealed that 20 recovery rooms were located on the same floor as the operating room, while 25 were located near the surgical division.

The third part of the questionnaire sought to determine the types of cases for which the recovery room was used. The hospitals were asked to classify recovery room patients according to types of anesthesia used and also according to types of surgery performed. It was found that the majority of patients recovering from general and spinal anesthesia were taken to the recovery room. In addition, varying percentages of patients receiving all other types of anesthesia were reported to use the recovery room.

A survey of the types of surgical cases taken to the recovery room also showed a wide variety. The recovery room was used for practically all types of surgery except obstetrical cases, eye cases, and communicable diseases. From these facts, it is concluded that a rich and varied clinical experience for student nurses exists in the recovery room.

Replies to Part IV of the questionnaire indicated a centralization of equipment and facilities in the recovery room, making possible immediate and efficient patient care.

The purpose of another part of the questionnaire was to discover the activities of various personnel in the recovery room, particularly those of the nurse. It was found that the recovery room nurse is expected to assume most of the responsibility for the patient's care and must have a high degree of skill and knowledge. She must observe and interpret the patient's condition in addition to administering treatment.

AWARENESS OF IMPORTANCE

Answers received from the hospitals indicated an awareness of the importance of having well-qualified graduate nurses in charge of the recovery room. In the majority of the hospitals the graduate nurse had received supervisory experience in a related department. In addition, a number of the graduate nurses had backgrounds in other types of specialized skill or training.

It is suggested that still another prerequisite be placed upon recovery room supervisors. In addition to the required technical skills, the supervisor should be able to recognize student needs in order to provide learning opportunities and guidance for the inexperienced student nurse.

Part IX of the questionnaire pertained to the planned educational activities of students given recovery room experience. In 22 of the 42 schools, recovery room service was given following the student's operating room experience, thus adding another facet to the student's knowledge of the operative patient. The length of recovery room assignment varied from two days to eight weeks. This wide divergence indicates a need for further study to determine how extensive an assignment would actually be adequate.

We also made inquiry into the planned classroom and teaching activities designed to prepare the student in postoperative and postanesthesia nursing. Of the 42 schools in the survey, ward teaching was carried on in 15 and formal classes were conducted in 22. These classes were given as a unit of the surgical nursing course. From these figures it can be seen that classroom instruction is not always correlated with ward instruction.

In 20 of the participating schools, no attempt was made in the theoretical or clinical instruction to prepare the student for the care of patients recovering from anesthesia. However, the figures representing the schools which do provide some form of planned instruction are encouraging.

CONCLUSIONS

Today's hospital planning tries to provide both general and special services for all patients. The recovery room takes its place with other important therapeutic services. Present conditions have been recognized, by those familiar with the care of the postoperative patient, to be far from satisfactory. There has been so much effective agitation of the problem by the anesthesiologists, however, that many hospitals are no longer disposed to ignore the demand for the addition of postoperative observation rooms to their hospital facilities as a means of providing the student nurse with a concentrated period of clinical experiences in the efficient management of the anesthetic patient.

The student nurse needs to become more familiar with every emergency measure which she might be called upon to employ in caring for the anesthetized patient. Her skill in handling the postoperative patient with efficiency and with minimum difficulty will increase the student's confidence in her own ability.

In our study to find out the existing educational value in the assignment of student nurses to the recovery room, the following survey technics were used: Survey of literature, observation and personal interview, card questionnaire, and a detailed and comprehensive questionnaire.

The summary of the most significant findings is as follows:

1. The majority of recovery rooms are under the control of the nursing school office. This finding is contrary to the trend for the anesthesiologists to "assume an increasing responsibility for the postoperative patient."
2. Most hospitals provide for an eight-hour recovery room service. However, some, to meet their needs, have expanded this service to 16 and 24-hour service.
3. The recovery room offers sufficient equipment, facilities, and learning opportunities to provide excellent clinical experiences in the education of the student nurse in postoperative nursing care.
4. The requisite qualifications of the recovery room supervisor vary. However, most hospitals seem to use as a basis for the selection of the graduate nurse in charge, former supervisory experience in the surgical division and in the operating room.
5. The existing educational program offered to the student nurses in the recovery room varies, but it seems that an attempt is being made to utilize the learning opportunities inherent in the recovery room service to enrich the students' clinical experience in the management of the anesthetized patient.

RECOMMENDATIONS

On the basis of our findings, the following recommendations seem to be indicated:

1. That a study be made on two equated groups of students: one group that has had recovery room experience and one that has not, to determine the value of this recovery room experience in the clinical program.
2. That the functions of the registered nurse in charge of the recovery room be studied to determine the definite qualifications and the preparation of the graduate nurse in charge of the recovery room.
3. That a study be made to determine what knowledge of anesthesia is necessary in order to give efficient and adequate postoperative care to patients.

Recovery Unit Improves Care

By Mrs. Ethel I. West
Operating Room Supervisor
Methodist Hospital of Southern California
Los Angeles

Mrs. West

IT HAS long been felt that the immediate postoperative period was a critical time for patients, and that during this period they should be under the supervision and care of personnel expert in postanesthesia training. The surgeon and anesthesiologists, who necessarily are limited as to actual time spent with the patients following surgery, thus would be assured that the patient was receiving efficient nursing care. The responsible persons would be notified if progress was not satisfactory.

The recovery unit at the Methodist Hospital of Southern California, established to better meet present-day needs, is situated directly adjacent to the operating rooms. Its purpose is to give improved care to patients during the immediate postoperative period. Patients requiring the same kind of nursing care are concentrated in one nursing area where nursing time and special equipment are more efficiently utilized. Patients in various stages of recovery are not seen in corridors, elevators, or multiple areas.

The anesthesiology staff, in cooperation with the medical staff, has primary responsibility for the over-all management and coordination of the medical aspects, with the chief of anesthesia as coordinator. The nursing personnel become highly specialized in this phase of patient care and concentrated service without interruption, and the anesthesiologists and other members of the medical staff are nearby to give close supervision or any necessary emergency care.

STAFFING

The unit is a separate division of the department of nursing service, and is under the over-all supervision of the operating room supervisor, with a head nurse in charge of the unit. At present, it is staffed according to the needs of the department, and also to include training of professional and vocational students.

We have proved the following advantages in having the recovery room adjacent to the operating rooms:

- The anesthetists, or other members of the medical staff, are easily available for emergencies. We have had two such cases. In both instances, the patients hemorrhaged, and without delay were wheeled directly into surgery for emergency treatment.
- The operating room orderlies assist in transferring patients to and from the recovery unit.
- Linens are supplied by surgery, and sterilization of supplies is done by the operating room staff, thus eliminating the need for additional personnel to perform these duties.

Patients are transferred from the operating room table to special carts provided by the recovery unit and remain on these carts until they are transferred to their room beds. Children must be in *cribs*—not on carts.

In general, all postoperative patients, unconscious from a general anesthetic, are transferred to the recovery unit until they have reacted and become stabilized.

THE EXCEPTIONS

Patients go directly to the wards from the operating room when the maximum number of patients in the recovery unit would be exceeded, and none in the unit can be transferred out, or when they are:

1. Patients from the obstetrical division, including newborns
2. Surgical cases considered contaminated and treated as such in the operating room
3. Local anesthesia patients
4. Spinal anesthesia patients, except those who are unconscious from combination types of anesthesia
5. Selected cases, according to doctor's preference, in which it is better to move patients to their beds while unconscious
6. Patients with radium

However, any patients requiring close supervision following surgery are admitted to the unit.

Special nurses are allowed to care for their patients in the unit under the supervision of the recovery room personnel.

Priority in the unit is determined by the operating room supervisor according to the best interests of all patients, with the approval of the chief of anesthesiology.

Transfer out of patients is authorized by the anesthetist or attending surgeon. Orders for transfer may be verbal or by telephone.

No visitors are allowed in the unit, unless the patient's condition is critical. On such occasions, clergy, close relatives, and friends may be permitted to see the patient in a private room in the unit kept for this purpose.

An emergency buzzer connected in surgery brings prompt response for aid.

NO ADDITIONAL CHARGE

No additional charge is made for recovery room service to patients, except for extra drugs and treatments that are not included in the usual care of patients. The cost of operation of the recovery room unit is absorbed by the surgical nursing department. We feel that this has been justified because the unit helps to stabilize nursing service. It not only benefits the patients in the unit requiring immediate postoperative care, but provides decreased inter-

(Continued on next page)

ference in the routine care given to the patients on the divisions.

Before the patient enters the hospital, his immediate family is advised of the care and treatment he will receive in the recovery unit. This practice lessens fear and anxiety of the patient and also reassures the family that he is receiving special care.

FACILITY AND EQUIPMENT

The unit contains two patient areas, with the desk situated so that all patients are under constant observation. The medication cupboard, counter, emergency locker, and alarm buzzer are easily accessible to all patient areas. All lockers, cupboards, etc., are built in, leaving adequate floor space for easy moving of carts and for essential equipment in patient areas.

The work area is recessed to reduce annoyance of utensil and activity noises to patients.

Recovery carts have free turning wheels, two with lock brakes to stabilize carts while in the unit. Mattresses are covered with moistureproof, conductive material. Removable side rails are stored on the lower framework of the cart when not in use. Carts also are equipped with two safety belts, an I.V. standard, and shoulder braces. The only manual lift on the cart is at the head to place the patient in upright position. The foot of the cart may be cranked to tilt the patient in any modification of shock position in a matter of seconds.

TRANSFER OF PATIENTS

A crank on the side of the cart operates the duo-gear mechanism that moves the cart bed horizontally over the patient's bed, and continues to a 45° angle. Then three persons transfer the patient to his own bed with minimum effort. This method of transferring patients on the recovery carts has decreased the number of back injuries to personnel as a result of lifting.

Other equipment consists of:

Electric sterilizer
Gomco and Connell suctions
Barton spotlight
Dressing cart
Oxygen equipment
Drainage and irrigating sets
Emergency drugs
I.V. solutions and Vaco sets
Catheterization equipment
Refrigerator containing crushed ice for oxygen therapy, ice collars which are filled, ready for use
A work area, complete with waste hopper, scrub sink, linen hamper, etc.

METHODS AND PROCEDURES

Patients are received from 7 a.m. to 4:30 p.m., and length of stay in the unit is determined by the anesthesiologist in charge of the case.

On admission, the patient is checked in with the anesthetist who accompanies him to the unit. The anesthetist makes periodic checks on the patient during his stay and is called for special checks at the discretion of the charge nurse. The surgeon on the case visits the patient as soon as possible after admission.

ROUTINE PROCEDURE ON ADMISSION

Check:

1. Airway—mechanical and natural
2. Color of skin
3. Respiration—character and quality
4. Pulse—character and quality
5. Blood pressure (check admission and surgery course)
6. Capillary refill
7. Condition of skin
8. State of reactivity
9. Retention catheters, drain tubes, gastric tubes, etc.
10. Dressing, drains, drainage

POSTOPERATIVE ORDERS

Blood pressure cuff is adjusted to arm, a reading taken, and a verbal report made to the attending doctor. There is a cuff for each chart.

Blood pressure, pulse, and respiration are taken routinely every 15 minutes during stay, or more often if condition warrants closer observation.

Arms or feet getting I.V.'s are stabilized with gauze ties.

Retention catheters are checked, and if so ordered, are connected to drainage bottles at once.

Dressings are checked. If any drainage is present, size, character, and color are noted and charted.

ROUTINE ON DISCHARGE FROM UNIT

Patient is checked to see that he has:

1. Full orientation
2. Normal respiration
3. Suitable circulation
4. Blood pressure stabilized
5. No excessive bleeding, drainage, or discharge from operative site
6. Adequate drainage from retention catheters, drain tubes, gastric tubes.

On the patient's admission, his respective floor is notified of his arrival and general condition. If there is a drastic change in condition, the floor is notified.

If length of stay is predetermined and over three hours, the floor is given a condition report at mid-time. Example: Spinal fusions and laminectomies are routinely kept in the unit five hours, if possible; the floor is given a report in three hours. G.U. and urology cases are kept at least three hours.

Each patient is logged in on the unit daily record sheet. Room and bed number, name, surgeon, anesthetist, operation, anesthetic, and times of admission and discharge are noted.

Unit records include:

1. Patient's recovery sheet, which becomes part of permanent chart
2. Unit daily record sheet
3. Monthly report, which gives briefly the total number of patients, minimum and maximum time in unit, earliest arrival time, latest discharge time, average patient time in unit.

ADVANTAGES OVER OLD METHOD

We have found the following advantages to the patient in this method:

1. Constant specialized observation
2. Immediate availability of anesthesiologist and surgeon
3. Close proximity to surgery
4. Quiet, calm surroundings
5. Patient's feeling of security, safety, and assurance, resulting from immediate response of nurses when he requests attention
6. Immediate attention to emergency situations
7. Concentrated nursing service with specialized observation

Since our recovery unit has been in operation, valuable information has been verified in regard to care of post-anesthesia patients, such as the fact that positioning of patients influences blood pressure. From these studies, the surgeon is aided in the treatment of the patient after he leaves the recovery unit.

Physical Layout of the Recovery Room

Harriet B. Smith
New York Hospital
New York City

MUCH progress has been made in patient care in recent years, but probably nothing is of more interest or of more vital concern to us in anesthesia than the organization of the postoperative recovery room. Our responsibility does not cease the moment the patient leaves the operating room. The anesthetist's responsibility begins the minute anesthesia is administered and does not end until the patient's blood pressure, pulse, and respiration are stable; until he has completely recovered his reflexes, and is fully awake and oriented.

There is no more dangerous or more crucial time in a surgical patient's hospitalization than the immediate postoperative, postanesthesia period. A few statistics will verify this statement. In an article by Dr. Lowenthal on "Recovery Room: Life Saving and Economical," in the July, 1951 issue of *Anesthesiology*, it was reported by the Philadelphia Anesthesia Study Commission[1] that over an all-year period, there were 306 deaths related to anesthesia. Nearly half of these were classified as preventable, and 95 (or 63 percent) were the result of a combination of inadequate nursing care and respiratory obstruction.

Since similar results have occurred or are now occurring elsewhere, it is understandable that many hospitals are solving the problem by the organization of the postoperative recovery room.

Some advantages of a recovery room unit are:

1. Mortality and morbidity are decreased because such complications as respiratory obstruction, hypotension, hypoxemia, shock, and hemorrhage are prevented or recognized and treated immediately by trained and competent personnel.

2. Improved nursing care is given with a minimum of risk to the patient. Recovery room personnel usually are under the direct supervision of the anesthesiology department. They are especially trained to recognize and cope with the many emergencies arising in the immediate postoperative period.

3. The anesthetist and surgeon are always available if emergencies arise, and they may observe patients routinely between cases or as frequently as necessary.

4. With centralization of the postoperative patients in one area, fewer nurses are needed, and the amount of equipment required is less than if it had to be duplicated in several hospital areas.

5. Postoperative accidents, resulting from long transit from the operating room to the patient's room, are avoided.

6. Recovery room units lessen the work load and confusion on a busy surgical floor.

7. Other patients, as well as relatives and friends, are relieved of distressing sights and sounds sometimes associated with emergence from anesthesia.

8. Finally, the morale of patients and relatives is strengthened by the knowledge that the postoperative patient is under the constant care of skilled nurses, with the anesthetist and surgeon nearby.

Physical layout in the postoperative recovery room may be divided into several categories. The following discussion describes what we consider an ideal set-up. Many recovery room units vary in size, arrangement, and equipment, with equally good over-all results. Therefore, any attempt to organize and maintain a recovery room should be seriously considered and encouraged. Experience has proved that the results will be gratifying.

The location of the unit is most important. It should be on the same floor, and adjacent to, the operating room suite. This arrangement permits minimum postoperative transportation of the patient and insures prompt postoperative care and treatment.

The size of the unit depends on the maximum number of patients to be accommodated at one time. The following ratio, which takes into account the total number of hospital beds, operating rooms, and operations per day, has been worked out:[2]

1-4 O.R.'s require 1 R.R. bed/per O.R. plus 1
5-8 O.R.'s require 1 R.R. bed/per O.R. plus 2
9-12 O.R.'s require 1 R.R. bed/per O.R. plus 3

In other words, a 200-bed hospital, utilizing five operating rooms, averaging 20 operations per day, should maintain seven recovery room beds.

Many different factors enter into the actual setup of the recovery room unit. It should consist of one open ward with curtains to afford privacy for the conscious patient.

There should be a utility room plus ample cupboard and storage space for linens, medications, and equipment. In one end of the unit, there should be a glassed-off cubicle to accommodate the infectious cases.

Doors should be wide enough to permit the entrance of beds with special apparatus attached. Sufficient space around each bed (or stretcher) is very necessary. At times it must accommodate bulky equipment and allow personnel to move freely on all sides. A minimum of four feet between beds is recommended.

Conductive floors are necessary if the recovery room is adjacent to the anesthetizing area. Soundproofing of the room is recommended to minimize noise.

UNOBSTRUCTED VIEW OF PATIENTS

A most important factor is unobstructed visibility of patients from the work stations and nurses' desk. Therefore, the utility room should either be glassed off or have a large observation window.

Adequate lighting facilities must certainly be emphasized. We in anesthesia know the importance of good lighting in observing the patient's color or in detecting the slightest sign of cyanosis. Natural lighting is best. When artificial lighting is used, the indirect method is preferable. Some means of emergency lighting should be available. Electrical wiring should consist of one duplex outlet for each bed plus one heavy duty outlet in the unit for x-ray equipment.

Communication systems, besides the telephone, should include one or more emergency call buttons between the

[1]Presented by Ruth, Haugen, and Grove at the annual meeting of the Southern Society of Anesthesiologists, St. Louis, April 1, 1950.

[2]Galbrith, T. P., and Schafer, M. K., "Post-Anesthesia Post-Surgery Recovery Room Service," **Hospitals**, Vol. 26, No. 11, November, 1952, pp. 65-77.

(Continued on next page)

recovery room unit and the operating room suite. Individual call bells are not necessary.

Oxygen and suction must be available for each bed. The oxygen may be piped from a central supply or a manifold system adjoining the unit, according to the recommendations of the National Fire Protection Association. In many hospitals portable equipment is used instead of a central supply. If piped oxygen and wall suction are used, it is recommended that the outlets be placed 5′ 3″ high. Both should be gauge-controlled, with the suction and humidifier bottles fastened to the wall.

Air-conditioning is highly desirable, particularly if the operating rooms are air-conditioned. The temperature should be maintained around 72°, with 40-50 percent humidity.

The recovery room should have adequate plumbing facilies, including hot and cold running water for hand washing in the patient area. The utility room should have a double sink and sterilizer for cleaning equipment, as well as a bed pan flusher and disposal units for excreta.

At the New York Hospital-Cornell Medical Center we have been operating a 16-bed recovery room unit for over three years. It consists of five rooms, a utility room, and an office, with three of the rooms connected by open doorways. One single room is kept for contagious cases.

The recovery room operates on a 24-hour basis with personnel including one supervisor, one head nurse, six staff nurses, one nurse's aide, two orderlies, and one floor clerk.

PORTABLE SUCTION MACHINES

We use portable Sorensen suction machines (one to each two beds) and portable McLellan suctions for Levine tube aspiration. By each bed there is a "G" tank of oxygen with a meter gauge and an O.E.M. mask and bag for delivering the oxygen. A positive pressure oxygen mask is available for emergencies, and an Emerson respirator is kept in the unit at all times.

Two mechanical bed lifts, in addition to several wooden platforms, are used for placing beds in Trendelenberg position.

The unit is air-conditioned.

All patients receiving general or spinal anesthesia are returned to the recovery room in bed. One exception is made, as the intraocular surgical cases are returned directly to the eye service. Approximately 45-50 patients are cared for in the recovery room daily.

A postoperative recovery room can operate efficiently only through the closest cooperation of the surgeons, the anesthetists, and the surgical nurses.

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Chicago A.O.R.N. Installs New Chairman

Miss Anna Johnson, Cook County Hospital, Chicago, formerly first vice-chairman of the Operating Room Nurses' Section, First District, Illinois Nurses Ass'n, was recently installed as acting chairman of that organization. She replaces Miss Evelyn Owens, Chicago Wesley Memorial Hospital, who resigned to become chairman, Operating Room Section, Illinois State Nurses Ass'n.

Members of the executive committee of the Chicago group shown at right, are, standing (l. to r.): Betty Williams, Chicago Wesley Memorial Hospital, program chairman; Margaret Young, South Chicago Community Hospital, chairman, committee on rules; Bonnie Rogers, Augustana Hospital, Chicago, second vice-chairman; Mary Alice Grusbeck, Cook County Hospital, chairman, nominating committee. Seated: Miss Owens (l.), and Miss Johnson. Absent are: Irene Thompson, Walther Memorial Hospital, Chicago, chairman, committee on membership; and Audrie Price, Presbyterian Hospital, Chicago, secretary.

The O.R. Problem Clinic

by EDITH DEE HALL, R.N.

Booking Nasal Reconstructions for Surgery

● Problems concerning the booking of operations exist in many hospitals and the rules concerning the task are varied and numerous. This duty may be assigned to the operating room supervisor, a clerk, or some other person. Perhaps the best and most popular method is to place bookings in the hands of a nurse who has an understanding of the complete plan. A special effort is made to schedule all operations that are pressing or urgent, even though it may be inconvenient.

General surgery cases usually take precedence over cases which appear to be of lesser importance. Perhaps no operation falls into the latter category more often than the rhinoplasty or nasal reconstruction. Let us consider the time, place, and importance of this operation.

If a special department is provided for plastic surgery, problems in booking are usually at a minimum. In hospitals where all surgery is performed in one department, nasal reconstructions are apt to be placed near the end of the list to comply with rules which were made with little thought to good planning. In giving service to patients, consideration must be given to operations which can safely wait. A better understanding of nasal reconstructions may prove helpful.

Plastic surgery dates back to the fifteenth century and its history is to a large extent the history of nasal repair. The prominence of the nose in plastic surgery is explained by its prominence on the face, and the surgeon's goal is to provide good function and reconstruct the nose so that it is in harmony with the rest of the face.

Surgery of this type may be necessitated by injury causing a displacement, fracture or partial loss. Malformation and disturbance to the function of the nasal passages may also be the reason for surgery. The surgeon's aim cannot be realized by surgical skill alone as this specialty is an art as well as a science.

The conscientious plastic surgeon will demand substantial reason for the correction of any external abnormality of the nose. It is not enough for the malformation to exist; it must be serious enough to mar the appearance of the face or threaten social and economic opportunity. A conspicuous nose may exert a profound influence over temperament and disposition, and its bearer is entitled to relief from the mental anguish it occasions.

In considering the time for bookings for nasal reconstructions, it is true that so far as safety is concerned these cases are not urgent. The patients, however, do make definite arrangements at home and at work, often waiting and sacrificing to obtain the necessary funds. Although the hospitalization period is comparatively short, the whole ordeal is of utmost importance to the patient.

From the standpoint of the O.R. nurse it is generally agreed that this operation requires a minimal amount of service after the case has been started. Preparation of the room, instruments, and supplies is fairly simple as compared to that necessary for more radical surgery. Nasal plastics may be tedious and time consuming, requiring a special skill on the part of the surgeon, but it is not too difficult to provide good service and release specially trained nurses for more difficult assignments. When placed properly in the schedule, nasal reconstructions may be advantageous in cutting down the confusion and overcrowding which may occur if all rooms are booked for radical or complicated surgery.

Thought should be given to the importance of nasal plastic operations. Children and adults alike suffer physically from a disfigurement and no one can hide an external defect of the nose. An example of this is supplied by a 65 year old man with a long humped nose. An old fracture and displacement of the bones had caused an obstruction of the nasal passages. This condition was greatly aggravated by common colds.

He was referred to a plastic surgeon but complained only of the obstruction. When asked about the shape of his nose the man readily agreed to having it changed. Several months after the operation he returned to the hospital and proudly displayed the result. He also admitted that for years he had been self-conscious and that he always drove a car to work so that he could be alone. If it was necessary to use the subway, he always read a newspaper to prevent people from staring at his nose.

This case is mild as compared to many more drastic, and even tragic, cases on record. Frequently the correction of a trivial defect succeeds in re-establishing emotional stability and prevents the development of grave psychoses.

Nasal reconstruction does have a place on the operative schedule for the same rule always holds—we must consider the patient.

* * *

Mid-South OR Nurses To Hold Institute

An operating room institute for mid-south operating room nurses will be held at the Peabody Hotel, Memphis, Tenn., February 8-9. The institute will be sponsored by the Memphis Association of Operating Room Nurses in cooperation with the Mid-South Post-Graduate Convention.

Included in the program will be talks by various leaders in the field, panel discussions and a problem clinic.

For further information on this institute, contact Frances F. Rose, R. N., president, Memphis Association of Operating Room Nurses, John Gaston Hospital, 860 Madison Ave., Memphis 3, Tenn.

Question Box

Each month questions pertaining to O. R. problems and technics will be answered by Dr. Carl W. Walter, nationally known for his operating room technic courses and as the author of "Aseptic Treatment of Wounds" (MacMillan). Questions should be addressed care of the O. R. Editor, Hospital Topics.

Q. I have read The O.R. Yearbook Vol. 4 *in which an article of yours "Methods of Sterilization" appeared. Could you answer these questions for me please?*

(1) *We have a regular steam sterilizer that is not automatic.*

a. *Can this be used as a dry heat sterilizer?*

b. *Do sterilizers have a control to determine the heat and pressure? (Ours never seems to get above 250-260 degrees F. and 18-20 pounds of pressure.)*

c. *How often should this sterilizer be thoroughly scraped and cleaned?*

d. *Can you explain the term "super-heated steam" more thoroughly?*

(2) *In my short O.R. career of one year in two hospitals I have never seen gloves sterilized more than 10 to 15 minutes, and had thought any longer time would be harmful. Hence, I was surprised to see your information in the Question Box stating 30 minutes at 250 degrees F., and that they should be hydrated. I had never heard of this hydration before either.*

We have been having considerable trouble with our gloves and cannot find out the reason why. We have been washing them in a blood dissolving product. Would you have any idea what might be the trouble? We do not hydrate them, could this be why? I think it would be rather hard to persuade my supervisor to sterilize gloves 30 minutes unless you gave me an absolute insistent answer. I certainly would appreciate it.

A. Any jacketed sterilizer can be used for dry heat sterilization by turning steam into the jacket only.

The temperature of the steam in a sterilizer is measured by a thermometer placed in the air exhaust line. The pressure is indicated on the gauges.

Chapter 21 of *Aseptic Treatment of Wounds* deals in detail with the maintenance of sterilizing equipment. After you have perused its contents, I will gladly answer any further questions.

If you heat a cup of water, that water turns to steam known as saturated steam. If you then add more heat to that steam, in which there is no liquid water, you have superheated steam. The various ways this can happen in sterilizing practices are described in Chapter 7 of *Aseptic Treatment of Wounds.*

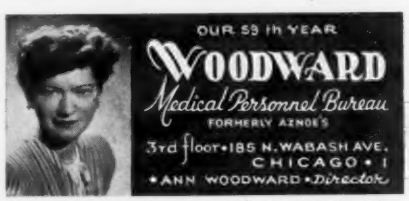
If rubber gloves are sterilized alone, 15 minutes at 250 degrees F. is adequate for sterilization. If, however, they are sterilized with other objects which require a prolonged heating time, 30 minutes at 250 degrees F. is indicated. I do not feel that the added exposure has any effect on the rubber. Gloves should be washed in a mild alkali solution (Oakite), dried thoroughly and powdered with Bio-Sorb. Immediately before being placed in the sterilizer, the packages are sprayed lightly with distilled water. On removal from the sterilizer they are allowed to dry on the shelves for 48 hours before being used so that the rubber may regain its tensile strength. The staff in the operating room should be instructed to rinse off their gloves before removing them to prevent blood from drying and caking.

Q. In sterilizing syringes on a tray such as on arteriogram and pneumoencephalogram trays, is it safe, from a sterility standpoint, to sterilize them with the plunger inserted into the barrel under steam sterilization, rather than separating them and wrapping each part, which consumes so much space on the already crowded trays? In Aseptic Treatment of Wounds, *and as I remember from your class, you say it is best that syringes be sterilized by dry heat which is impossible in this case, or that under steam pressure sterilization the plunger and barrel should be separated. Is this absolutely necessary for safe sterilization?*

A. If syringes are sterilized assembled in a steam sterilizer they are likely to be unsterile in that moist heat does not reach the inside of the snugly fitting barrel and plunger, the ground glass is attacked by the water, and the alkali leached out will subsequently destroy a large percentage of drugs used. Syringes when sterilized by steam must be separated.

Q. In the December, 1952, issue of HOSPITAL TOPICS, you stated that the walls in the operating room should be cared for in a routine housekeeping schedule. What do you consider "a routine housekeeping schedule?"

A. A routine housekeeping schedule is an individual problem depending upon circumstances of use, personnel, and geographic location. An analysis of these circumstances will reveal how often a general housekeeping should be effected. Gross contamination of the walls



Founders of the counseling service to the medical profession, serving medicine with distinction over half a century.

Selected Opportunities

POSITIONS OPEN

O. R. SUPERVISORS: (a) Admin abil; suite of 8 rms; vol gen hosp 300 bds; Los Angeles area; (b) Active surg serv; apprv'd 150 bd gen hosp; attrac twn 35,000; SE. (c) Reorganize, admin dept & teach; suite 6 rms; lge teach'g hosp; univ city; MW. (d) Gen hosp 400 bds; resort city; Fla. (e) Lge, fully apprv'd gen hosp; active surg serv; nr NYC. (f) New 50 bd gen hosp; attrac twn; Iowa. (g) Pref w/degree; suite 5 rms; gen hosp 250 bds; twn 50,000; Pac NW. (h) 450 bd gen hosp; average 500 surg proc pr mo; attrac coll twn; S. (i) Lge teach'g hosp; 6 major ORs; to $4800; univ & resort city; MW. (j) Vol gen hosp 75 bds; apprv'd JCAH; lge city; E. (k) Suite 8 rms; gen hosp 350 bds; lge univ city; MW. (l) New 60 bed gen hosp; attrac twn 10,000; S.

should be removed as soon as it occurs. The floors should be vacuumed daily and mopped between cases with a germicidal solution such as sodium hypochlorite.

Q. We are considering air conditioning in our two operating rooms if this can be done in compliance with safe operating room practice, and without overwhelming expense.

It is my understanding that you have a wealth of knowledge and experience pertaining to all types of operating room equipment, and I was wondering if you would advise us in the practical solution of our problem.

A. A practical solution to your air conditioning problem is to install a package unit of adequate capacity in each room. If installed above five-foot levels, such units are perfectly satisfactory for the purpose and, indeed, are much less expensive and perform better than a central system which is installed with all the necessary duct work.

Q. Will you please tell me how much damage vacuum will do to rubber gloves at the close of the sterilizing period?

A. I do not believe that vacuum will damage rubber gloves at the close of the sterilizing period. It should serve to dehydrate the gloves and return the rubber to its normal tensile strength a little sooner than would occur naturally. Vacuum at the induction of the sterilizing cycle, however, is harmful in that it causes the rubber to superheat and is thus responsible for deterioration of the rubber during the sterilizing period.

Q. In some of the larger hospitals the sterile tables are set up covered and kept in the halls, or placed in a room for the following day's use. Others in turn keep their sterile tables set up for several cases in the same room.

We would like to know your opinion of this technic since some of the doctors of our surgical staff have asked us to use these methods in order to save time.

A. Every patient should have an individually wrapped and sterilized kit of supplies which should be opened when the patient and operating team are all assembled in the operating room, and not before. A sterile set-up which has been draped is not considered safe for use inasmuch as it invites contamination by curious people and insects. The use of common supply tables for sterile equipment is a hazardous and obsolete technic which should be abandoned.

Careful selection and arrangement of materials in pre-packaged kits insures a safe technic which saves time in the operating room. The technic described in Chapter 14 of *Aseptic Treatment of Wounds* requires no more than five minutes for the preoperative arrangement of supplies and instruments.

Q. After preoperative skin prep is it necessary to tape a sterile towel over the area, until the patient goes to surgery?

A. Nothing is accomplished by draping shaved skin with a towel except inflicting unnecessary apprehension and discomfort on the patient and succeeding in keeping the skin hot and moist with resulting proliferation of bacteria. Really, for an elective procedure, the patient should be instructed to scrub the operative site for five days preoperatively with any detergent or soap containing hexachlorophene.

He thus presents himself for surgery with the bacterial flora of the skin suppressed to the vanishing point. When the patient is positioned on the operating table, a lather is worked up on the skin with sterile gauze, the area shaved with a sterile razor and then disinfected for surgery by any one of several technics.

Q. I would appreciate any information you could give me concerning the proper sterilization of felt.

A. Felt can be sterilized in saturated steam at 250 degrees F. as any other textile. Care must be taken that packages do not become too thick and heavy to allow penetration in the usual time allowed for sterilization.

Q. As one part of an attempt to provide the best possible hospital environment for our patients, we are impregnating all linen with an oil solution prepared and distributed commercially by the Penn Oil Company.

We should be indebted to you if you could answer a question which has originated in the minds of some physicians on our staff; namely, does oil impregnation of linens, presuming proper application and dilution, impair the ability to properly sterilize linen used in delivery rooms, surgical suites, and in certain specialized dressings? The question has arisen in view of the fact that the oil, whether T-13 or the emulsion we are presently using, forms a coating on individual fibers of the linen.

A. I do not think that the oils used in impregnating linen interfere with sterilization inasmuch as they are dispersed throughout the fibers rather than present as an impenetrable layer. However, I do not have any actual data on which to base a positive answer and would like to reserve such an answer until there has been time for some bacteriologic studies.

Q. What do you think of the practice of the "circulator" dropping articles from a wrapper onto a sterile field? Would "tossing" it onto the sterile field be permitted, if the hand and wrapper did not reach the sterile field?

A. Sterile supplies may be safely dropped on a sterile field by competent personnel if care is taken to guard against contamination with the loose ends of the wrapper or the hand and arm of the person transferring the supplies.

To provide a convenient holder for caps and masks, Rosamond Poole, O.R.S., Providence Memorial Hospital, El Paso, Tex., designed this simple two-pocket bag of green cloth, hung on a suction-cup bar purchased at the dime store. It is placed adjacent to the scrub sinks, just outside the operating room.

C | D R Y | SINK | GLASS | BLOOD | WRAPS | SOLUTIONS | RECEIVING

(Continued from page 29)

Purchasing Agents Install Officers

Installation of officers of the Hospital Purchasing Agent Association of the Pittsburgh area was held recently.

New officers are Mrs. Dorothy M. Durst, president; Dona M. Banze, vice-president; Mrs. Ethel Walters, secretary-treasurer; and William Riesmeyer, S. S. Dugan, Jr., Peter Mosbacher, and Rose Abels, members of the executive committee.

Cancer Society Elects New President

Howard C. Taylor, Jr., M.D., director of the obstetrical and gynecological service and professor of obstetrics and gynecology, Columbia University, has been elected president of the American Cancer Society.

Appoint Neal W. Cirlot Public Relations Manager

Neal W. Cirlot has been appointed public relations manager of the Mississippi Blue Cross-Blue Shield Plan.

Before coming to Blue Cross-Blue Shield, Mr. Cirlot was Mississippi representative for the Commerce Clearing House, a topical law reporting firm.

The new department will be directed by Mr. Cirlot.

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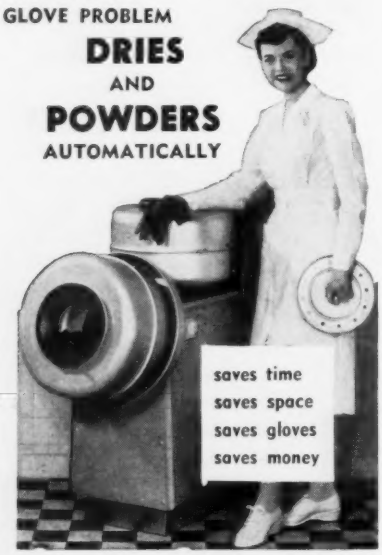

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American Hospital Supply Acquires V. Mueller & Co.

Acquisition by American Hospital Supply Corp. of all the assets of V. Mueller & Co. has been announced.

By acquiring the facilities of the 59-year-old V. Mueller and Co., American will enter the individual physician market and the wholesale-retail surgical supply market. Previously, American sold principally to hospitals and related institutions and, through its Scientific Products Division, to laboratories.

V. Mueller & Co. has major sales, service and distribution facilities in Chicago, Rochester, Minn., Dallas and Houston. Its sales representatives are established in 17 states. Included in the consolidation is the V. Mueller & Co. subsidiary, Star Surgical Instrument and Manufacturing Co., located in Chicago.

Merrell Sponsors Symposium On Gerontology

A one-day symposium on "Constructive Medicine in Aging: Predictable Stresses in Middle Life" attracted more than 300 physicians to Cincinnati recently to hear papers presented by some of the nation's leading authorities on gerontology.

Sponsored by the Wm. S. Merrell Co., the scientific session was part of a long range program recently adopted by Merrell in its concentration of research in the field of geriatrics. Last fall Merrell dedicated a new gerontological laboratory and its scientists are dedicating themselves to the development of drugs aimed at the chronic diseases of later life, according to Nelson M. Gampfer, Merrell president and general manager.

Merck & Co. Makes Two Appointments

In a major organizational move, the board of directors of Merck & Co., Inc., has appointed two Sharp & Dohme Division executives to new top management posts.

Henry W. Gadsden has been named vice president of Merck & Co., Inc., reporting directly to company president James J. Kerrigan. Appointment of John G. Bill as vice president and general manager of the Sharp & Dohme Division was simultaneously announced.

Mr. Gadsden joined the sales research department of Sharp & Dohme in 1937. Following his election as vice president in 1949, he was appointed a director in 1952.

Mr. Bill began his career with Sharp & Dohme in 1925 as a sales representative in the New England district. He became general sales director in 1947 and was elected vice president in 1949. He was appointed a director of Sharp & Dohme in 1952.

Miles Laboratories Buys Bischoff Co.

Walter R. Beardsley, president of Miles Laboratories, Inc., Elkhart, Ind., has announced completion of negotiations for the purchase of the Ernst Bischoff Co., Ivoryton, Conn., manufacturers of biologicals and pharmaceuticals for almost 50 years. The Bischoff Co. will be merged with the Ames Co., subsidiary of Miles Laboratories.

Charles F. Miles, president of the Ames Co., stated that an expanded sales and development program is being planned for the Bischoff line and that the facilities in Ivoryton will be maintained and enlarged.

General Electric Elects Vice President

Robert L. Gibson has been elected vice president of the General Electric Co. General manager of G-E's Chemical and Metallurgical Division, Mr. Gibson was one of three G-E executives named vice presidents by the board of directors. The others are Francis K. McCune, general manager of the company's Atomic Products Division, and Willard H. Sahloff, general manager of the Small Appliances Division.

Coty Named Clay-Adams Vice President

C. Kenneth Coty has been named vice president in charge of sales for Clay-Adams Co., Inc. Mr. Coty joined the firm in 1953 as general sales manager.

He was previously central sales manager of the Bauer & Black Division of the Kendall Co.

McGrew Receives Promotion at Abbott Laboratories

R. F. McGrew, manager of the Reading, Pa., sales district for Abbott Laboratories, has been promoted to eastern division sales manager. He fills the vacancy created by the death of John Frank Richmond last November.

Mr. McGrew will have his office in Philadelphia. He had been district manager since September, 1953.

Lever Names Parkinson Glycerine Sales Manager

Laurel G. Parkinson has been appointed glycerine sales manager for the Industrial Division, Lever Brothers Co. He replaces C. Clyde Oliver who has retired after 30 years service. Mr. Parkinson was formerly assistant glycerine sales manager.

Central Supply

CABINET | DRY GOODS | SINK | GLASS | BLOOD | WRAPS | SOLUTIONS | RECEIVING

a section of special interest to

Central Supply Room Staff

contributions are welcome

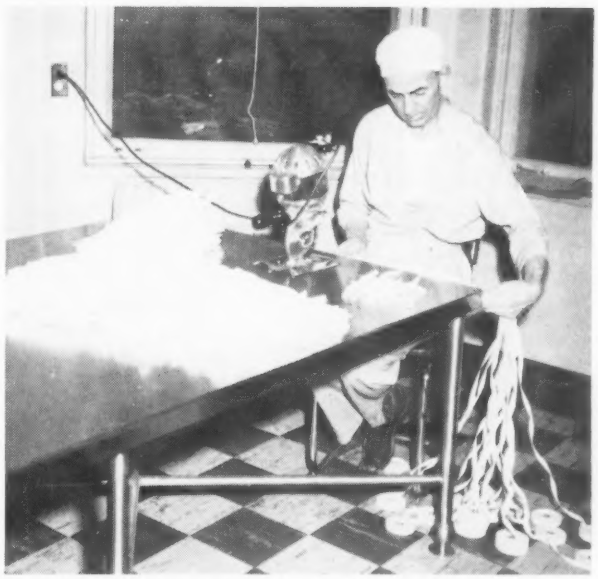
C. S. at Cook County Hospital a Major Operation

When a hospital is over five times larger than what would ordinarily be termed a "large" hospital, its central supply department becomes not merely a service, but a major operation.

The newly modernized central supply department at Chicago's 3,260-bed Cook County Hospital, for example, has a daily linen count that runs into the thousands. Where the average central supply room might process a few hundred rubber gloves per day, the department here is equipped to process a few hundred per hour. Bandaging is ordered not by the pack (except for the sterile, fine-mesh type), but by the bolt. Each bolt is run through a loom-like machine which cuts it into various bandage widths. These bandages then are packaged according to size in dozen lots. About 400 such lots are packaged per month.

Rooms in the department are designated not by number, but by letter—and they use up half the alphabet, A through M. Practically each of these 13 rooms is larger than the entire central supply department in most hospitals.

(Continued on page 78)



Above: Strips used as ties for gowns and surgical masks are bought in rolls and cut to size. About 15 or 16 strips are cut at a time.

Below: A corridor view of Cook County's central supply department. Seen through the window is William C. Brunner, R.N., supervisor.

Above: IV and hypodermoclysis sets are washed and hung on racks to let the water drip out of the tubing. After they have been examined and processed, they will be wrapped in muslin and autoclaved.

Above: Bandaging used for non-sterile purposes is bought by the bolt and run through a bandage-cutting machine which can be set to any width. After bandages have been cut they are packaged according to size in one-dozen lots.

Formerly the hospital's central supply department was located on three different floors. With the opening of the newly modernized department in April, however, the rooms now are located all on the same floor and are conveniently adjacent to one another.

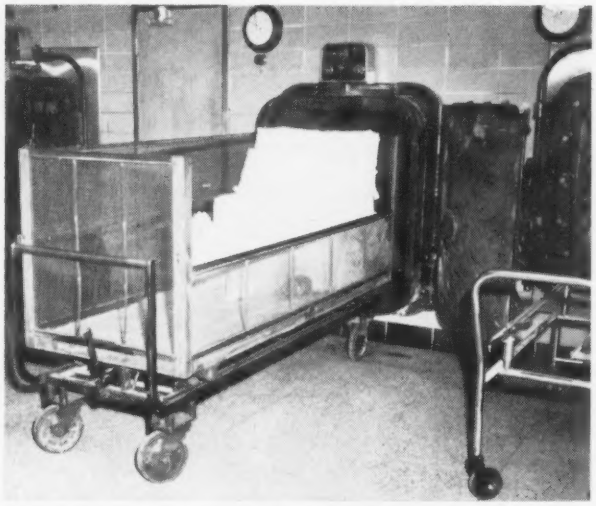
Requisition books provided to each ward, for the purpose of ordering supplies from the central supply department, also are labeled with letters—A through I. The most important items are listed in book A; less important items in books C, D, E, and so on, down the line to the minor items listed in book I. Book "B," incidentally, is used solely for write-in items—special articles, or items so new that they have not yet been listed on the regular forms.

For all of the department's vast size, however, and its huge daily volume of turnover in supplies, it operates with smoothness and efficiency. Breakage and loss of the numerous items which daily flow in and out of the department is almost negligible. Out of 858,571 syringes of all sizes dispensed during 1953-54, only 12,055, or about 0.14% were broken or lost. Breakage and loss of most other items was even lower. William Brunner, R.N., supervisor of the department, attributes this fine record to incessant teaching, conscientious checking on carelessness, and efficient packaging.

The hospital, administered by Warden Fred A. Hertwig, serves an important function as a teaching institution in the Chicago area. Hence, it is necessary that the central supply department be perpetually abreast of the newest trends and procedures in the field. In-service staff education programs are carried on continually. Meetings, at which staff members are encouraged to freely thrash out their problems, are held twice a month for all associational and professional personnel. An outstanding authority on some new trend or procedure in the field is presented at each meeting to keep the staff members informed of new developments.

A pictorial review of Cook County Hospital's vast and modern central supply department is continued on the following page.

Below: Rubber gloves, which formerly were washed manually in the individual wards, now are washed in the department's three Westinghouse laundromats. After gloves have been loaded in machine (each machine holds 200 gloves), they are given a ten minute prewash followed by a regular washing with warm water and detergent. Speedup in washing afforded by the machine enables the department to turn out 1,500 gloves in five and one-half hours.



Left: Standing at the entrance to a huge autoclave is one of the department's linen carriers. After the carrier has been fully loaded, it will be rolled into the autoclave and linens will be sterilized without being removed from the cart.

Right: An attendant (at Cook County non-nursing personnel are called attendants rather than aides), prepares catheters for autoclaving. Each catheter is placed in cellophane tubing and labeled with a ticket which states its type and size.

Left: All clean and sterile supplies are stored in the department's vast dispensing room. All incoming orders are received and filled here.

Right: Syringes, hypodermoclysis, IV, and special sets (irrigating, "Y" IV, and respirator IV), as well as instruments used for minor surgery, all are cleaned and processed for sterilization in one large workroom. Attendants seated at table are processing syringes.

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MHA Public Relations Officers Elected

The Public Relations Section, Massachusetts Hospital Association, recently elected officers for 1955.

Mrs. Soma A. Weiss, community relations consultant, Massachusetts General Hospital, Boston, was named chairman; and Kenneth Jamron, director of public relations, Beth Israel Hospital, Boston, is secretary.

Military Surgeons

(Continued from page 23)

The radiographic findings were recorded so that the results could be analyzed in two ways—the total number of conditions found, and the number of individuals exhibiting the specified condition.

Results of the study indicate that the six-film radiographic examination gives a limited view of the mouth because of the number of films used. Generally a good view was given of all of the posterior teeth, the lower incisors, and the upper central incisors. The cuspid teeth were not visible, and frequently one or both of the upper lateral incisors were distorted so they could not be read. In some cases the lower first bicuspid and third molar apices were not recorded.

Despite these limitations, the special six-film series of radiographs used in this study permitted the observation of about 80 percent of the areas where oral pathology (not observable in a clinical examination) might be expected to occur. This type of examination detected approximately 90 percent of the oral pathologies found in the 14-film examinations of the 50 patients studied.

Although the six-film series does not provide sufficient coverage to be useful in clinical practice, it appears that the method might be adaptable to mass screening programs.

THE BOOK CORNER

(Continued from page 46)

improvement of the profession. For over a quarter-century she was editor of the American Journal of Nursing.

In this book, Miss Roberts discusses the step-by-step progress of nursing in this country. Her interest is in the education of the nurse, and it is reflected in her generous discussion of nursing schools, their teaching personnel, and their accomplishments.

The book is well documented, and provides an accurate picture of the nursing scene in America from its origin somewhat over a century ago to the present date. It should prove of interest to the student or graduate, in that it portrays the difficulties as well as the progress seen by the founders of this great profession.

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